NHS SCOTLAND

THE STATE HOSPITALS BOARD FOR SCOTLAND

BOARD MEETING

THURSDAY 28 OCTOBER 2021
at 10am, held by MS Teams

A G E N D A

1.	**Apologies**		
2.	**Conflict(s) of Interest(s)** To invite Board members to declare any interest(s) in relation to the Agenda Items to be discussed.		
3.	**Minutes** To submit for approval and signature the Minutes of the Board meeting held on 26 August 2021	For Approval	TSH(M)21/08
4.	**Matters Arising:**		
	Actions List: Updates	For Noting	Paper No. 21/70
5.	**Chair's Report**	For Noting	Verbal
6.	**Chief Executive Officer's Report**	For Noting	Verbal
10.20am	**COVID-19 RESPONSE**		
7.	**Covid 19 Response and Remobilisation:**		
a.	**Resilience Update** Report by the Chief Executive	For Decision	Paper No. 21/71
			Paper No. 21/72
b.	**Finance Update** Report by the Director of Finance & eHealth	For Noting	
10.40am	**CLINICAL GOVERNANCE**		
8.	**Clinical Model** Report by the Medical Director	For Decision	Paper No. 21/73
9.	**Corporate Parenting Plan 2021-2023** Report by the Director of Nursing and Operations	For Decision	Paper No. 21/74
10.	**Medical Education Report** Report by the Medical Director	For Noting	Paper No. 21/75
11.	**Medical Appraisal and Revalidation Annual Report 2020/21** Report by the Medical Director	For Noting	Paper No. 21/76

12.	**Quality Assurance and Quality Improvement** Report by the Head of Corporate Planning and Business Support	For Noting	Paper No. 21/77
13.	**Clinical Forum** Approved minutes - meeting held 27 July 2021 Chair's Update – meeting held 28 September 2021	For Noting	CF(M) 21/04
	*** BREAK 11.20am to 11.30***		
11.30am	**STAFF GOVERNANCE**		
14.	**Attendance Performance Report** Report by the Interim Director of Human Resources and Staff Wellbeing	For Noting	Paper No. 21/78
11.40pm	**CORPORATE GOVERNANCE**		
15.	**Finance Report to 30 September 2021** Report by the Director of Finance & eHealth	For Noting	Paper No. 21/79
16.	**Perimeter Security and Enhanced Internal Security Systems Project** Report by the Director of Security, Estates and Resilience	For Noting	Paper No. 21/80
17.	**Digital Transformation – Update** Report by the Director of Finance & eHealth	For Noting	Paper No. 21/81
18.	**Risk and Resilience Annual Report 2020/21** Report by the Director of Security, Estates and Resilience	For Noting	Paper No. 21/82
19.	**Complaints Annual Report 2020/21** Report by the Board Secretary	For Noting	Paper No. 21/83
20.	**Audit Committee** Approved minutes - meetings held 17 June and 22 July 2021 Chair's Update – meeting held 6 October 2021	For Noting	A(M)21/03 A(M)21/04
21.	**Corporate Risk Register** Report by the Director of Security, Estates and Resilience	For Decision	Paper No. 21/84
22.	**Board and Committee Schedule 2022** Report by the Board Secretary	For Decision	Paper No. 21/85
23.	**Any Other Business**		Verbal
24.	**Date of next meeting** 23 December 2021		Verbal
25.	**Proposal to move into Private Session, to be agreed in accordance with Standing Orders.** Chair	For Approval	Verbal

Estimated end at 1.pm

THE STATE HOSPITALS BOARD FOR SCOTLAND TSH (M) 21/08

Minutes of the meeting of The State Hospitals Board for Scotland held on Thursday 26 August 2021.

This meeting was conducted virtually by way of MS Teams, and commenced at 10am.

Chair: Brian Moore

Present:

Non-Executive Director	Stuart Currie [Item 7 onwards]
Non-Executive Director	Cathy Fallon
Employee Director	Tom Hair
Chief Executive	Gary Jenkins
Vice Chair	David McConnell
Director of Finance and eHealth	Robin McNaught
Non-Executive Director	Pam Radage
Director of Nursing, AHPs and Operations	Mark Richards
Medical Director	Lindsay Thomson

In attendance:

Director of Workforce	Linda Davidson
Person Centred Improvement Lead	Sandie Dickson [Item 8]
Consultant Psychiatrist	Khuram Khan [Item 10]
Head of Corporate Planning and Business Support	Monica Merson
Board Secretary	Margaret Smith [Minutes]
Lead Dietician	Frances Waddell [Item 10]
Director of Security, Resilience and Estates	David Walker [Item 18 onwards]
Personal Assistant	Julie Warren
Interim Director of HR and Wellbeing	John White

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

Mr Moore welcomed everyone to the meeting, and apologies were noted from Dr Sheila Howitt (Chair of the Clinical Forum) as well as Ms Caroline McCarron (Head of Communications). Mr Moore welcomed Ms Davidson to the meeting, in her capacity as Director of Workforce, and noted that this would be the final meeting for Mr White before his retirement. He also noted that it would be the last meeting for Mr Hair in his capacity as Employee Director prior to his retirement.

It was noted that Mr Currie and Mr Walker were necessarily engaged elsewhere for the first part of the meeting, and that they would join as soon as possible.

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 22 July 2021 were agreed to be an accurate record of the meeting.

The Board:

1. Approved the minute of the meeting held on 22 July 2021: TSH(M)21/07.

4 ACTION POINTS AND MATTERS ARISING FROM PREVIOUS MEETING

The Board received the action list (Paper No. 21/54) and noted progress on the action points from the last meeting, with actions either being completed or progressed satisfactorily.

The Board:

1. Noted the updated action list.

5 CHAIR'S REPORT

Mr Moore provided an update to the Board in relation to his activities since his appointment as Board Chair on 6 July 2021.

He had met with the Clinical Forum at their meeting in July and found it very beneficial to be able to connect with them in this way. This is something that he will be focussed on taking forward in the future. He had also received an update on work being developed in Communications, and confirmed that further reporting on the themes and issues in this area would come back to the Board.

Mr Moore asked the Board to note that he had also met with the Board Development Lead at NHS Education for Scotland (NES) along with the Chief Executive, Head of corporate Planning and Business Support, and Board Secretary. This was in relation to the active governance workstream. In particular, to help facilitate planning for a development session for Board members on how information for assurance was fed into the Board and its committee structure. He highlighted that this would be concerned with both the quantitative and qualitative mix of information, and how this supports good governance questioning skills. This work was linked to the ongoing review of the NHS Scotland Blueprint for Good Governance. A further meeting would be set up for Mr Jenkins and Ms Merson with NES to ensure good understanding of the unique nature of The State Hospital (TSH) and its performance metric framework.

He had also completed his training in security and in the Prevention and Management of Violence Aggression within the hospital, and aimed to be on site in the hospital once a week.

Mr Moore asked the Board to note that with his appointment to Board Chair, there was a vacancy for the Non-Executive Whistleblowing Champion and that the recruitment process for this was being considered by Scottish Government. In the meantime, any concerns raised through the policy could be brought to the attention of any of the Non-Executive Directors.

Mr Moore provided an update from the last meeting of the NHS Chairs, which took place on 23 August. This has included discussion on the public consultation on a national adult social care service, and noted that this was not expected to have direct impact for TSH. There had been an update on how Annual Reviews would be conducted throughout NHS Scotland this year, with a roll out of further information for boards expected shortly. The Vice Chair, David McConnell, had attended the afternoon session of this meeting and provided an update in this respect. This had been attended by the Cabinet Secretary for Health and Social Care, Mr Humza Yousaf, as well as the Minister for Mental Wellbeing and Social Care, Mr Kevin Stewart. Professor Jason Leitch, National Clinical Director, was also in attendance. The session focused on a national update on the Covid-

19 pandemic, as well as other serious public health concerns relating to mental health especially deaths from suicide and related to drug and alcohol addictions. The session had also included updates on work being progressed recovery planning for NHS Scotland including the redesign of emergency care, and the consultation into the development of a national social care service.

The Board:

1. Noted this update from the Chair and Vice Chair.

6 CHIEF EXECUTIVE'S REPORT

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

He confirmed that the Board Chief Executives had met and reviewed progress on the General Medical Services (GMS) Contract & Memorandum of Understanding, with the GMS Group taking forward transitional plans.

In terms of Covid Recovery, CEOs continued to focus on remobilisation of NHS Scotland, as well as on the wider consequences including pre-existing health inequalities. The Systems Pressures Group has been established to replace the winter pressures group led by the Chief Operating Officer for NHS Scotland, Mr John Burns, to assess key priorities especially unscheduled care. Board Chief Executives noted the public consultation on the National Care Service.

In this session, Mr Jenkins had introduced Mr Gavin Gray, newly appointed Deputy Director within the Mental Health Directorate who then provided an overview of challenges within this remit. There was consideration of the Barron report into the Delivery of Forensic Mental Health Services, and agreement that NHS Boards should continue with existing plans for the delivery of forensic mental health services, to allow the national policy position to be developed.

Resilience planning for NHS Scotland for COP26 in November was underway, with each Board considering preparedness. The CEO group received updates on the UK infected blood inquiry as well as the CMO Taskforce into forensic medical services relating to victims of rape and sexual assault. They also reviewed workforce strategy within NHS Scotland in the context of recovery planning and the urgent planning actions required to support this, as well as the framework for national pay negotiations.

Chief Executives received a presentation covering the challenge of developing a performance and planning model in the context of the recovery process from the pandemic during the current year, and transition to Annual Operational Plans expected to cover a three-year period, and to develop the strategic focus underpinning this. They considered integrated care pathways particularly around cancer care and the work being progressed by the Centre for Sustainable Delivery.

Chief Executives were joined by Ms Angela Constance, Minister for Drugs Policy, who outlined the key asks of NHS Scotland particularly in relation to the rising number of drug-related deaths. Health Boards were asked to work with Integration Authorities and Alcohol and Drug Partnerships to drive change and improvement.

Finally, Chief Executives noted the Afghanistan crisis internationally, noting possible impacts in the delivery of required health and care services for refugees.

The Board:

1. Noted the update from the Chief Executive

7a COVID 19 RESPONSE - RESILIENCE REPORTING

A paper was received from the Chief Executive (Paper No. 22/55) to provide the Board with an overview of the continuing response to Covid-19 by TSH and to provide key updates to the Board on actions taken since the date of its last meeting.

Mr Jenkins provided the Board with an overview of the report. He highlighted that the TSH Remobilisation Plan (version 4) was being developed presently and that an update would be brought to the Board Seminar on 23 September 2021.

He outlined the leadership and governance arrangements and the review of same underway. He added an assurance that incident command arrangements could be stood up by exception, should this be required. In relation to the proposed standing down of the Scientific and Technical Advisory Group (STAG) Professor Thomson added assurance that the components of the group's work, including the prevention and control of infection and modelling and surveillance work, would continue to be managed through the Infection Control Committee and/or the Corporate Management Team.

Mr Jenkins also noted the formation of two new groups in the form of the Strategic Planning and Performance Group, and the Sustainable Management Group.

He led the Board through updated reporting specific to the delivery of the Interim Clinical and Support Services Policy including patient and staff testing and vaccination programmes, including future requirement for booster vaccinations. Mr Jenkins noted the high patient numbers currently experienced, and the link to patient flow throughout the forensic estate particularly in respect of the provision of medium secure services.

Within the workforce section, Mr Jenkins asked the Board to note that dedicated reporting would follow in this meeting in relation to attendance performance, but that a higher level of absence was currently being experienced connected to both covid related absences as well as longer term sickness absence. Recruitment initiatives were focused on the appointment and induction of staff as quickly as possible, and Mr White added that additional resources had been recruited within the Human Resources Department which would help to support this. Performance in relation to personal development reviews for staff continued to be very strong within TSH. Overall the staff wellbeing framework continued to demonstrate the different layers of support being offered to staff.

Mr McConnell asked about leadership structures and what the early indicators on that were for the Board. Mr Jenkins advised that this work was progressing positively, and advised that internal auditors had supported a review of governance during July and August, with reporting to be brought to the Audit Committee in October 2021. Mr Currie added that it would be helpful to map the management group structure to that of the board governance committees, and to link the performance metrics into that structure – for example how an individual metric was reported through each layer of governance and up to the Board itself.

Action – Ms Merson/ Ms Smith

Ms Fallon asked for an update in relation to pastoral support services, and Mr White confirmed that this was being finalised through a service level agreement with NHS Lanarkshire, and recruitment was expected shortly. Informal support was in place in the transition period.

There was detailed discussion round the table on the presentation of this report, with agreement that is was a very helpful and comprehensive reporting mechanism which provided specific assurance to the Board across a range of areas and metrics. The Board confirmed that the format and breadth of reporting should stay in place, but that reduced detail was required particularly in those areas where there had been no change since the last Board meeting. Mr Jenkins gave thanks to colleagues for their continued focus and work to respond to the pandemic, as well as to Ms Smith for her work in supporting reporting of this to the Board.

The Board:

1. Discussed and noted the position outlined in this report in respect to the ongoing operational management and governance of the organisation in response to the global Covid-19 pandemic.
2. Agreed that the current comprehensive Covid-19 Resilience Report format and reporting requirements to the Board would continue in this area to provide consistent and concise assurance.

7b COVID-19 RESPONSE - FINANCIAL GOVERNANCE AND EHEALTH UPDATE

A paper was received from the Finance and eHealth Director (Paper No. 21/56) to provide the Board with an update on financial governance to date, during the Covid-19 pandemic, and reporting of specific Covid-19 related costs to Scottish Government.

Mr McNaught confirmed that specific Covid-19 related costs continued to be formally reported to Scottish Government regularly, and that reporting had been submitted in July for Quarter 1 and this also included forecasting for the first half of the financial year. Discussion with Scottish Government on this forecasting would take place in September – for TSH these costs continued to relate to staff costs and contingent project costs. Potential impacts leading into Quarters 3 and 4 would also form part of these discussions.

He also provided the Board with an update on progress of a number of workstreams within eHealth, given the importance of the digital agenda in supporting the continued recovery from the pandemic. A full report would be presented to the next meeting of the Board.

Questions and discussion followed and the tight timescales for reporting were noted, and Mr McNaught was asked for a further view on whether it was likely that the second half of the year would be impacted by Covid-19 related costs. Mr McNaught considered that this was likely, though for TSH the impacts would not be as considerable as those for territorial boards.

Mr Currie noted that the Scottish Government Programme for Government would be published in early September, and that £1b had been earmarked for the NHS, and in response Mr McNaught noted that formal confirmation would be awaited before this could be included in projected financial planning. Mr Jenkins added that TSH would be connected into national programmes focussed on mental wellbeing.

Mr McConnell welcomed the update on eHealth priorities, and asked that training resources could be shared with Non-Executive Directors, for example for MS Teams. The national position on the rollout of O365 was also noted.

The Board:

1. Noted the updated advice on financial governance through the Covid-19 pandemic, and that the outcome of scheduled discussion with Scottish Government in September would be formally reported to the next meeting of the Board.
2. Noted the update on progress of workstreams, and that a full report would be presented to the next meeting of the Board.

8 PATIENT, CARER AND VOLUNTEER STORIES: CREATIVE REFLECTION

The Board received a report from the Director of Nursing, AHPs and Operations, as part of its regular reports on patient, carer and volunteer experience. Mr Richards introduced this item as an opportunity for the Board to hear a patient's feedback on meaningful activity and how this had impacted his wellbeing.

Ms Dickson, Person Centred Improvement Lead, joined the meeting to lead the Board through a presentation. This centred on creative work by a patient, an artist, who had painted a mural in the Family Centre. This work had been initiated following discussion on how the walls of the hospital could appear bare and clinical in appearance. This individual patient had commented that activity had to be meaningful rather than based on generalised requirements. He had been seeking purpose, and felt that he wanted to add a personal contribution to the life of the hospital community.

For this project, he had been accompanied by nursing staff to the Family Centre and he found that this time spent painting the mural also provided him with personal space for reflection as well as brightening the physical space with his artwork. During this time, he felt more acceptance as a person, not only as a patient. His message to the Board was to emphasise that this opportunity brought great benefit to him personally because the activity was meaningful and had a definite purpose. Ms Dickson shared a picture of the mural painting, and noted how this patient's feedback could help the hospital in planning and framing patient activity through making a connection to rehabilitative care.

Professor Thomson added her support to this patient's view on the importance of meaningful activity. Ms Radage agreed and asked whether this type of approach could be reflected on in taking forward the Supporting Healthy Choices programme which was also part of the meeting agenda. This presentation had brought to life the concept of person-centred care. Mr Richards underlined the co-production opportunities for patients and staff and how this should be used to inform the patient activity programme across the hospital.

Mr Currie supported this emphasising the importance of enabling patients, which would demonstrate the organisational willingness to listen to patient feedback and perhaps encourage further contributions building on a co-productive culture. He added that small differences could open up opportunities for change.

Mr Moore summed up the discussion by thanking Ms Dickson for her presentation, underlying the way this had generated thought and agreement on co-production in initiatives for patient activity. Mr Richards would link this to the review of patient activity workstream underway presently to ensure that this patient feedback was included and used to inform the project. The Board also asked that feedback was given to the patient regarding the positive impact the story had on Board members and the insight it provided into useful activity.

Action – Mr Richards

The Board:

1. Noted the content and the importance of patient feedback especially around meaningful activity, and the positive impact of co-production.
2. Agreed that Mr Richards should link this to the review of patient activity to ensure it was used to inform the work, and for feedback to be provided to the patient.

9 CLINICAL MODEL MAPPING

A paper was received from the Medical Director (Paper No. 21/57) to provide the Board an update on the progress made with the clinical mapping exercise undertaken as part of planning for the restart of implementation of the new clinical model.

Professor Thomson introduced this paper summarising the underlying mechanisms which led to the design if the model during 2019, reminding the Board that this work was necessarily paused due to Covid-19. A further desk-top exercise had been taken forward, clinically led, in respect of the patient group and how they would fit into the agreed model.

Ms Merson provided a summary for the Board on this exercise, describing patient flow through the hospital from admission and assessment, treatment, to discharge. She acknowledged that presently

due to patient flow across the wider forensic network, there could be additional pressure within TSH as was the case with the current model of care delivery. Professor Thomson then summarised the recommendation that this exercise found that the model fits the patient cohort, and emphasised the way that the model would support continuity of care with the clinical team (including the key worker) moving within TSH alongside the patient.

In relation to patient flow, Mr Jenkins added that during planning and design of the model, consideration had been given to the previous five years bed number data which demonstrated that the model fitted the patient cohort. At present, TSH did have an unusually high number of patients which was connected to the wider forensic estate but this did not prohibit planning within TSH to provide the optimal patient care model.

Mr Moore opened the discussion around the table, underlining that this was a major issue for the Board.

Ms Fallon noted assurance that this model continued to fit the patient group, and asked about whether there was an expectation that TSH would be providing care for female patients in the near future, following the recommendations in the Barron report into the delivery of forensic mental health services. She asked how the Board would meet resourcing needs of this, and if this would impact implementation of the clinical model. Ms Radage noted the current pressures in terms of patient numbers, adding that the good work evidenced here on the model should not be held back due to these pressures. She also voiced concern about the potential impact of provision of a female service.

Professor Thomson advised that should TSH be directed to open a female service, then this would need to be an entirely separate provision to the male provision and would mean the opening of a separate ward with no mixing. Professor Thomson added that a new service for females should not impact the provision of the male service.

Mr McNaught confirmed that this would require to be costed separately, and that this would be dependent on decision-making and direction from Scottish Government. Mr Jenkins underlined this point and added that any such service would require to be funded in advance and planned with suitable run-in period for implementation. A key consideration would be staffing, the costs and the time require to recruit to a new service. He also noted the potential of savings in care delivery that a ten ward model (for male provision) presented but that the re-start of the clinical model workstream meant that this work should be re-visited to ensure that all opportunities were properly considered in detail and within the scope of what was possible.

Mr Moore summed up for the Board, noting that there was agreement around the table for the two recommendations to re-start planning work for the model, and that there was support for a wider engagement of both patients and staff. He noted the number of variables that could impact TSH in the coming period of planning including national direction for female provision as well as patient flow across the forensic network, particularly in respect of medium secure services. The engagement work should include both patients and staff as well as the range of issues that could impact the model. The Board would be seeking recommendations at its next meeting in October 2021.

Action – Professor Thomson/ Ms Merson

The Board:

1. Noted the content of the report and update on the restart of the clinical model,
2. Noted the number of variables and factors that could impact on this including patient flow across the wider forensic estate,
3. Endorsed the plan for further engagement,
4. Requested an update on progress and detailed reporting on the whole range of issues discussed including emergent views from both patients and staff with recommendations for

the Board on the way forward.

10 SUPPORTING HEALTH CHOICES

A paper was received from the Medical Director (Paper No. 21/58) in relation to Supporting Healthy Choices, which focussed on the priority area for TSH of managing the physical health risks within the hospital's patients. Professor Thomson introduced the paper by describing the issue of obesity within the patient population and relating this to the obesogenic environment within TSH. She acknowledged that this was a longstanding issue for the hospital, and that a previous action plan had been implemented during 2016 to 2019, and that despite the efforts and focus at that time there had been little impact. This workstream was re-started in January 2020, but had to be paused due to Covid-19. It was now being refreshed and re-commenced and a draft action plan was in place which would be subject to consultation.

Ms Waddell joined the meeting and highlighted the key points of the plan for the Board, which was based on the principles of Realistic Medicine, output from workshop activity as well as updated advice from Public Health England in this area. The hope was to achieve change over a period of 18 months to two years through focus on the short, medium and long term aims outlined. She advised that this workstream would be enabled differently due to some key factors including recruitment planned for a full time project manager to support governance, and a health psychologist post, as well as the new activity coordinators within the hospital. Refreshed thinking and new approaches would be taken especially around catering provision, exercise and health passports. This would help focus on the need for radical change.

Mr Currie asked for clarification as to whether the plan was open to further change following the consultation exercise, and also asked the team to consider the eventuality of this plan not working and what action could then be taken for radical change given the key importance of this issue. Professor Thomson confirmed that the plan could change subject to consultation – she wished to underline the importance of this process so that patients were fully aware of the impacts, and noted their right of individual choice balanced against the environment provided. The key to making this work would be in the implementation of the plan, and buy-in from the patients.

Ms Radage supported the plan and noted its comprehensiveness. She emphasised the importance of adequate resourcing of the plan and this workstream. On the issue of patient adherence to health and care plans, she thought a helpful way forward would be through the Person–Centred Improvement Team to help to interest and engage patients on the benefits and what flexibilities could be found within their own plans.

Dr Khuram Khan also joined the meeting, and provided advice to the Board on the refreshed energy within the team to take this forward, and the commitment to resourcing given which would empower the initiative. He felt the plan to be detailed and inclusive and that its aims were achievable.

Mr Moore raised the question of the appropriate governance route and it was agreed that detailed oversight should be taken thought the Clinical Governance Committee but that reporting should also continue directly to the Board as agreed through its workplan given that it was a key issue for the Board. He summarised the Board's discussion as supporting the plan which was considered to be comprehensive, and that consultation should proceed on this basis with further reporting to the Board as outlined.

<u>The Board:</u>

1. Supported the Supporting Health Choice draft action plan and its consultation
2. Requested that they be advised on future progress and consultation within this key area of focus.

11 APPROVED MEDICAL PRACTITIONER STATUS

A paper was received from the Medical Director (Paper No. 21/59) noting that following recruitment of two Forensic Psychiatry Specialty Doctors, it was necessary for the Board to consider the approval of their Approved Medical Practitioner status in line with the Mental Health (Care and Treatment) (Scotland) Act 2003

The Board:

1. Approved and formally placed said two Forensic Psychiatry Specialty Doctors on The State Hospitals Board's list of Approved Medical Practitioners.

12 QUALITY ASSURANCE AND QUALITY IMPROVEMENT

A paper was received from the Medical Director (Paper No. 21/60) to provide the Board with an update on the progress made towards quality assurance and improvement activities since the last Board meeting in June 2021. Ms Merson presented this paper to the Board the key areas of activity. She summarised the work completed on Quality Assurance focussed on clinical audits and variance analysis tools, as well as the indicator reporting linked to the Interim Clinical and Support Services Operating Procedure. She also outlined the work progressed through the Quality Forum, and capacity building within the hospital for Quality Improvement. She provided an update in relation to Realistic Medicine, confirming that a Project Manager was now in post. Finally, she summarised the evidence for quality including analysis if national and local standards recently released.

Mr McConnell asked about TSH connectivity to the Centre of Sustainable Delivery as a national initiative especially given the progress of the Realistic Medicine workstream and wider consideration of how to focus on innovation or different approached. Although the work of the centre may not be directly relevant to TSH, Ms Merson confirmed that the hospital is linked through national fora which ensures awareness of TSH should there be any opportunities for development in the future.

Mr Moore thanked Ms Merson for a very comprehensive report and confirmed the Board's support for this workstream as an important one for the hospital.

The Board:

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

13 CLINICAL GOVERNANCE COMMITTEE

The Board received and noted the approved minutes of the Clinical Governance Committee meeting which took place on 6 May 2021 (CGC(M) 21/02).

Ms Fallon updated the Board on the key areas of discussion at the further meeting which had taken place on 12 August 2021. This included a detailed update on the continuing response to Covid-19, learning from complaint handling, as well as reporting on adverse events. The Forensic Network action plan had been accepted by the committee as having been completed. The minutes would be presented to the Board once they had been approved by the next meeting of the committee.

The Board:

1. Noted the approved minutes of the meeting of the Clinical Governance Committee which took place on 11 February 2021, and the update from the most recent meeting of the committee.

14 CLINICAL FORUM

The Board received the agreed minutes (CF(M) 21/02) of the meeting of the TSH Clinical Forum which took place on 25 May 2021.

The Board:

1. Noted the minutes of the meeting of the Clinical Forum which took place on 25 May 2021.

15 ATTENDANCE PERFORMANCE REPORT

The Board received a paper from the Interim Director of Human Resources and Wellbeing (Paper No. 21/61) outlining the high level position on staff attendance for the most recently reported period to June 2021. Mr Moore acknowledged that Ms Davidson had now commenced in her role as Director of Workforce, and that she would present this paper to the Board.

Ms Davidson introduced the paper by noting that this is a high level report on attendance performance and that it indicated a more challenging positon for the Board, following a period of improved performance. In June 2021, the sickness absence rate had increased to 6.58%, against the target for the Board of 5%. She highlighted the split between long and short term sickness absence, and advised that the department was taking a focussed review of the factors affecting longer term absences with line managers to ensure that all staff were receiving the support needed.

Mr Currie asked what about what actions could be taken in particular to help to prevent short term absences becoming more long term. Ms Davidson emphasised the importance of managers keeping communication links open with the affected staff member to help understand the reason for the absence and any underlying factors so that support can be targeted. Mr Currie also asked if consideration was given to redeploying staff in order to encourage their return to work, and Ms Davidson confirmed that this was the case as part of the wider consideration taken in each case to make reasonable adjustments for a supportive environment.

Ms Radage, Chair of the Staff Governance Committee, added that the committee took a detailed overview of attendance performance. Although TSH was experiencing challenge, benchmarking to other secure settings did indicate that this did appear to be an area of challenge across these environments more generally.

Mr Moore concurred and summarised for the Board that the positon was noted, as well as that detailed oversight was being taken by the Staff Governance Committee as an area of concern.

The Board:

1. Noted the content of the report.

16 WHISTLEBLOWING REPORT – QUARTER 1, 2021/22

The Board received a report from the Interim Director of Human Resources and Wellbeing (Paper No. 21/62) detailing the update on the first quarter for the current year.

Ms Davidson then outlined this update for the Board, confirming that one case had been received since the launch of the new policy on 1 April 2021. This case had been investigated at stage 2 within the standards, and currently feedback was sought from the complainant. A further report would be presented to the Board once this was finalised.

Ms Davidson also advised that training on the whistleblowing policy and standards was available through the TURAS platform for all staff.

Mr Moore confirmed that a bulletin had been issued to all staff at the time of the re-launch of the policy, and that this message should be continuously reinforced to build awareness and ensure that staff were comfortable about using the policy and embed this into the culture of the organisation. He added that given that appointment of a new Whistleblowing Champion to the Board was awaited, it should be clear that any Non-Executive Director could be approached for advice in this regard.

In terms of reporting requirements, he noted that an Annual Report should also come to the Board in the future.

The Board:

1. Noted the content of the report.
2. Noted the vacancy of Non-Executive Whistleblowing Champion, and agreed the position that any Non-Executive Director could be approached during this period.

17 STAFF GOVERNANCE COMMITTEE

The Board received and noted the approved minutes, SGC(M) 21/02, of the Staff Governance Committee meeting which took place on 20 May 202.

Ms Radage advised that a further meeting had taken place on 19 August 2021 with the minutes to follow. In the meeting, the committee had focused on review of the Occupational Health Service, staff wellbeing, recruitment and staffing levels, as well as the Staff Governance Standards Monitoring Return for 2020/21 which was due to be submitted to Scottish Government by 30 September.

The Board:

1. Noted the approved minutes of the meeting of the Staff Governance Committee which took place on 20 May 2021.
2. Noted the update form the Chair of the Staff Governance Committee.

18 CORPORATE GOVERNANCE IMPROVEMENT ACTION PLAN

A paper was submitted to the Board (Paper No. 21/63) by the Board Secretary, which detailed the improvement plan that was developed to support key corporate governance priorities as part of the NHS Scotland Blueprint for Good Governance.

Ms Smith provided an overview of the paper, which summarised the areas of the plan which had been identified as key areas of development by the Board when it had met in April 2021. She added that progress had been made more widely since this time in a number of other areas, as part of the recovery process.

She advised the Board that Item 2 relating to effective rostering would form part of the next Board Seminar scheduled for 23 September, when a detailed update would be presented by Mr Richards.

Ms Smith asked the Board to consider four more areas in terms of the progress made, and whether these could now be considered closed as part of this plan. These were implementation of national human resources policies, review of the performance metrics framework, risk reporting and also defining TSH culture focussed on staff wellbeing.

Ms Smith then provided further background on suggested ways forward in respect of items 12 and 13 which related to the arrangement of public board meetings and how to encourage public attendance. She acknowledged the constraint that the pandemic had placed on holding these meetings in person, and placed this within the context of other gains in that virtual meeting had supported attendance, and this could help reach the public in a national context. With COP26 and environmental action becoming of crucial importance, public bodies also had to take this into

consideration for arranging in person meetings. The recommendation was to move to a hybrid model considering ways of combining virtual and in person attendance.

She also updated the Board in relation to Items 19 and 20, covering senior leadership connection and Non-Executive Director visibility and the progress being made in these areas.

Mr Moore thanked Ms Smith for a helpful presentation and opened the discussion. Mr McConnell noted that this plan should align to the work being progressed through the Corporate Governance Steering Group which reported to the NHS Chairs Group. He also asked for more information on live streaming board meetings and how this compared to practice across NHS Scotland. Mr Currie picked up on this point noting that live streaming was common practice in local authorities. He was supportive of a move to a hybrid model, and noted that individual circumstances may mean that this could be a supportive and inclusive way forward for both the Board and the public. He added that lesson should be learnt in terms of considering the carbon footprint of the previous model of in-person meetings.

Professor Thomson underlined that a hybrid model should be carefully described and that equity of participation should be key to this. She suggested that a combination of in person and digital meetings could be considered.

Ms Fallon agreed that this was a comprehensive report, and also that hybrid model of arranging board meeting and this would being different dynamics to the conduct of the meetings. She emphasised that she was pleased to see the planned re-start of leadership walkrounds and that she would be keen to participate. Ms Radage echoed these sentiments especially around Non-Executive Director presence on site when possible. Mr Richards advised that the Infection Control Committee would be considering this further in its next meeting in September and that advice would follow.

Mr Moore added his own thoughts and then summarised for the Board. He was mindful of advice from auditors around governance and the need for public meetings, and that a hybrid model could support this. The Board should move forward to consider both opportunities and possible challenges.

He then noted that the Board agreed to close the items suggested, except for item 7 relating to performance metrics given the continuing work with NES and the session on active governance which would take place shortly.

<u>The Board:</u>

1. Noted the content of this report
2. Welcomed the developing planning for future public board meetings to provide an inclusive platform encouraging attendance and the new initiatives in digital platforms.
3. Endorsed the key areas of development, and agreed to closing items 6, 9 and 15, with a further update on item 7 to be brought back to the Board.

19 FINANCE REPORT TO 30 JUNE 2021

A paper was submitted to the Board (Paper No. 21/64) by the Director of Finance and eHealth, which provided a high level summary on the financial performance to month three - 30 June 2021.

Mr McNaught presented a summary of the key aspects of the report, with the Board reporting an underspend of £0.019m to the end of this period. He noted the key financial pressures for the Board and work progressed to identify savings. He advised that national boards continue to work towards joint efficiencies and collaborative working.

Mr McNaught confirmed that a breakeven positon was anticipated in respect of both revenue and capital for this financial year.

Mr McConnell asked about assessment of savings as reported, and whether there was any concern

on achievement of these given the positon at this stage of the cycle. Mr McNaught advised that progress to date was as expected and that this was reflected by some redress to date during Quarter 2, and therefore this had not given rise to particular concern.

Mr Moore finalised discussion for the Board, noting that members were content to note this report.

The Board:

1. Noted the content of this report.

20 PERFORMANCE REPORT – QUARTER 1, 2020/21

A paper was submitted to the Board (Paper No. 21/65) by the Head of Corporate Planning and Business Support, which provided a high level summary of organisational performance through the reporting of Key Performance Indicators (KPI's) for Quarter 1 April – June 2021.

Ms Merson provided the Board with a summary of the key points from the report advising that trend data was included to demonstrate comparison of performance with previous years. She led the Board through the detail of the report including performance in relation to relevant national standards as well as the additional local Key Performance Indicators (KPIs) which were reported to the Board.

She highlighted the four KPI areas which were reporting as off target: 6 monthly review of care and treatment plans, offering an annual physical health review, healthier BMI, and staff sickness absence rate.

In relation to the review of care and treatment plans, Ms Merson advised that there was no underlying concern raised that these reviews were taking place; but that the target had been missed due to administrative failures to upload the information timeously. This was being reviewed to gain improvement.

In relation to annual physical health reviews, the KPI was defined as the offer of a review, rather than measuring uptake. The definition of the KPI was under review to ensure that it did capture the uptake reflecting measurement of physical health needs. A Practice Nurse had been appointed and the Health Centre was refreshing management and delivery of this.

Ms Merson noted that the Board had received reporting during this meeting on the Supporting Healthy Choices workstream linked to the KPI of healthier BMIs, as well as an update on attendance performance including sickness absence rates and the work being progressed for improvement in this area.

The Board:

1. Noted the content of this report detailing the positive picture overall across the range of measures for delivering the aims of the hospital. The Board discussed those measures where further progress was required, and would continue to receive regular updates.

21 PERIMETER SECURITY AND ENHANCED INTERNAL SECURITY SYSTEMS PROJECT

The Board received a report from the Director of Security, Estates and Resilience (Paper No. 21/66) detailing the update of the Perimeter Security and Enhanced Internal Security Systems re-fresh project and planning for the remainder of this year with completion of works expected in April 2022.

Mr Walker confirmed that then information contained in this report was for noting at this stage and it was confirmed that the Board was content to do so. It was proposed and agreed that additional reporting would be brought to a private session of the board, given the commercially sensitive nature of the update, as well as the confidentiality required in respect of security arrangements at the hospital.

The Board:

1. Noted this update,
2. Agreed that a further update should be provided within the private session of the board.

22 CORPORATE RISK REGISTER

The Board received a paper (Paper No. 21/67) from the Director of Security, Estates and Resilience, which provided an overview of the medium, high and very high risks featuring on the Corporate Risk Register, and to provide assurance that these were being addressed appropriately. Mr Walker summarised this report and highlighted the key points contained therein.

The Chair confirmed that the Board noted the report and did not consider that discussion at today's meeting had indicated that any further amendment or addition should be made to the Corporate Risk Register. However, the section within the report relating to governance and the relevant oversight committee for each risk should be reviewed - especially around wither the risk was owned within the executive management structure, or referred to the Board.

Action – Mr Walker

The Board:

1. Noted the content of this report, and provided a view that this recorded and evaluated organisational risk appropriately, with no further amendment or addition suggested to the listed risks.
2. Requested review of the link to oversight committees.

23 BOARD AND COMMITTEE MEMBERSHIP

A paper was submitted to the Board (Paper No. 21/68) by the Board Secretary, which noted that the tenure of the previous Chair of the State Hospitals Board for Scotland ended on 31 December 2021. The Board noted that following the recruitment exercise which was concluded in July 2021, confirmation was then received from Scottish Government that the new Chair had been appointed for a two-year term. Mr Brian Moore took up this appointment on 6 July 2021. Given this, Mr David McConnell's tenure as Interim Chair was concluded and he has reverted to his role as Vice Chair of the Board.

The Board:

1. Noted the previously approved the changes to the governance committee membership to reflect the recent appointment of Board Chair.

24 ANY OTHER BUSINESS

Mr Moore note that this was the final Board meeting for both Mr Hair as Employee Director and Mr White as Interim Director of Human Resources and Wellbeing, as each would be retiring shortly.

He paid tribute to Mr Hair for his service to the Board, and Mr Jenkins added his own thanks especially for the enthusiastic way in which Mr Hair had represented staff views. Mr Moore then paid tribute to Mr White highlighting his very balanced approach and the great work achieved in supporting staff especially through the wellbeing workstream. Mr Jenkins added his thanks to Mr White for his contribution and wished him well for his retirement.

25 DATE AND TIME OF NEXT MEETING

The next public meeting would take place on 28 October 2021.

26 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 1340 hours

ADOPTED BY THE BOARD

CHAIR

DATE

Paper No: 21/70

NHS SCOTLAND

THE STATE HOSPITALS BOARD FOR SCOTLAND
ROLLING ACTION LIST

ACTION NO	MEETING DATE	ITEM	ACTION POINT	LEAD	TIMESCALE	STATUS
1	February 2020	Clinical Service Delivery Model (Item 7)	Update on key milestones for delivery – overall financial monitoring and recording on Corporate Risk Register.	R McNaught/ M Merson	Paused in April 2020 – now restarted with update on progress to Board – August 2021	**Considered as part of Board Seminar (May 31st) and agreement to preparatory work for re-start of implementation during 2021.** **Updated – August 21 – Reviewed and new action added for implementation process including governance. CLOSE**
2	February 2021/April 2021	Resilience Report – Covid-19 (Item 7a)	Provide benchmarking comparison to other organisations on use of virtual visiting	R McNaught/ D Walker	June 2021	**August: Update included in Covid response report at Item 7a. Full report to be brought to October meeting** **Update: 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.
3	February 2021	Board Public Meetings (Item 23)	Review route to enable this and if possible to route to patient cohort	M Smith	August 2021	**Considered as part of Corporate Governance Improvement Plan August 21 meeting and then at board seminar meeting 23 September. Plan to review in spring 2022 depending on national covid situation. Updated on CGIP and will be brought back as part of board workplan. CLOSE**
4	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	December 2021	**Work in progress as part of performance metrics / active governance and update to be brought back to board.**
5	August 2021	Patient Story: Creative Reflection (Item 8)	To ensure that this patient's feedback on meaningful activity is fed back into the patient activity workstream, and that patient is made aware of impact of story.	M Richards	Immediate	**Confirmed that feedback highlighted to operational team to be included in workstream/patient feedback given – CLOSE**

6	August 2021	Clinical Model (Item 9)	Board accepted update and asked for recommendations on next steps for engagement and implementation to be brought to next meeting.	L Thomson/ M Merson	October 2021	**On Agenda: Update report on agenda for board to consider.**
7	August 2021	Corporate Risk Register(Item 22)	To review the oversight committee for each risk –clarify executive /board oversight.	D Walker	October 2021	**On Agenda as part of reporting.**

Updated – 19.10.21 – M Smith

Author:
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Board Secretary
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Paper No. 21/ 71

NHS SCOTLAND

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	28 October 2021
Agenda Reference:	Item No: 7a
Sponsoring Director:	Chief Executive
Author(s):	Board Secretary
Title of Report:	TSH Response to Covid 19 Global Pandemic – Update
Purpose of Report:	For Decision

1 SITUATION

This report provides an update to the Board on the continuing response to the global Covid-19 pandemic by The State Hospital (TSH) by prioritisation of strategies to protect the health and wellbeing of both patients and staff; and to minimise as far as possible the risk of transmission of the virus through staff and patient populations.

NHS Scotland will remain on an emergency footing until at least 31 March 2022, and TSH is following Scottish Government guidance in relation to any requirement for restrictions within the health and care setting.

The Board has received reports at each of its meetings throughout the pandemic, to set out the actions taken as well as remobilisation planning. At its last meeting in August 2021, the Board agreed that this form of reporting should continue to provide transparency and to support good governance through accountability.

2 BACKGROUND

This report will provide the Board with a detailed update on the framework through which TSH has continued to manage its response to Covid-19, since the date of the last Board meeting. Further to provide an update on the submission of the updated TSH Remobilisation Plan, which was focussed on the last two quarters of this financial year.

2.1 Senior Leadership and Management Structure

Management Structure:
The revised management structure which was first brought into being in December 2020 continues to be kept under review. To ensure that the organisation is continuing to consider the effectiveness of the revised governance arrangements, the Board Secretary undertook a detailed review of the structure and how it is functioning.

This involved using a desk-top method to measure concrete factors around functionality (such as availability of agreed terms of reference, minutes, actions trackers, established meeting schedules). Separately a self-assessment survey tool was rolled out to each group in the structure with questions on understanding of remit and purpose, quality and flow of reporting, and effectiveness of decision-making. The survey also asked about individual and departmental engagement with the governance group.

This exercise extended to the Corporate Management Team (CMT) the Organisational Management Team (OMT) and the Hospital Management Team (HMT) as well as the governance groups which underpin this structure.

In addition, the Organisational Development Lead has completed a development exercise with the Hospital Management Team. HMT then set up a sub-group to prepare a response to this and to provide a final report which was submitted to the CMT.

On 28 September 2021, the CMT held a dedicated development session to review and discuss the findings linking the two workstreams, and found them aligned in their findings. Overall, these have supported the view that the new layered structure is an improved governance structure for the hospital, is more streamlined with more effective decision-making. There is generally a positive feeling about partnership working within this structure. At the same time, some specific minority views are held that are concerned about changes in governance and leadership.

The key recommendations have been that there continues to be appetite for change, especially around the effectiveness of engagement and decision-making within TSH and how this relates to the culture of the organisation. The CMT has accepted that this supports the position that the over-arching structure of the CMT, OMT and HMT should continue as the governance structure of TSH. Further that, the Board Secretary should continue to link with each of the groups which underpin this structure so that each group can take ownership of their assessment, and consider the results and any recommendations made to help support their development. In addition, that the approach taken here should be embedded within TSH as a dynamic means to progress good governance practice. The development work around HMT is also progressing led by its Chair to help support and build upon the role this group plays within the hospital, and its link to hub management and clinical leadership structures.

Management of Covid-19 Support:
Dedicated support for the response to Covid-19 continues to be provided through a range of disciplines and departments from infection control, clinical operations, human resources and administrative services. Since the date of the last Board Meeting, the hospital has experienced two outbreaks of Covid-19 and this required an Incident Management Team to be stood up in support. This is outlined in the following section (at Section 3.3).

The Incident Command Structure can be stood up urgently, should this be required. On 1 September, this was stood up over a period of several days to ensure the organisation could support operational activity whilst experiencing challenges in staff availability.

The Board received reporting at its last meeting on the re-routing of STAG through pre-existing governance structures, notably an enhanced Infection Control Committee. TSH has developed a link to the Horizon Scanning Team in NHS Lanarkshire. The CMT has continued to receive monitoring and surveillance reporting, at local, regional and national levels.

2.2 TSH Remobilisation Plan 2021/22 – Updated September 2021

The Remobilisation Plan for the period 1 April 2021 to 31 March 2022 has been reviewed for any additional actions required in the second two quarters of the current year, and the draft plan was presented to the Board at their seminar session which took place on 23 September.

Following this the plan was submitted to Scottish Government by the deadline of 30 September 2021, and it is expected that the governmental response will be received by 31 October, along with confirmation that the updated plan can then be published.

3 ASSESSMENT

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

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

The Board is aware that delivery of care throughout the pandemic has been managed through the TSH Route Map and the Clinical and Support Services Operational Policy. The aim has been to effect a phased remobilisation to support rehabilitative and therapeutic activity for TSH patients, whilst planning service delivery in alignment with the Scottish Government Route Map. The policy remains subject to regular scrutiny and review, underpinned by data gathering and a formal fortnightly review meeting through the Operating Model Monitoring Group. There have been no changes made since the policy update effective from 15 June 2021. These governance arrangements continue to be reviewed through the CMT to ensure that reporting on key indicators continues at the appropriate level within the governance framework.

3.2 Infection Control Committee

The Infection Control Committee has reviewed its term of reference and now meets monthly with enhanced oversight for the management of Covid -19 within TSH. National Guidance on infection control requirements is reviewed for any impact on TSH. The programme of Covid-19 audit work is being conducted as part of the wider programme of infection control audit. As well as leadership for infection prevention and control within TSH, additional support continues to be provided by the Infection Control team in NHS Lanarkshire.

3.3 Covid-19 Incidence

Should a patient be symptomatic and require testing, practice is to isolate the relevant ward and to carry out contact tracing for that patient. This is whilst testing of the patient is conducted and reported upon. Should a positive PCR test be reported, the whole ward will isolate (as a household model).

Staff follow national guidance on the need for PCR testing and self-isolation, including isolation exemption where the staff member has been double vaccinated, completes a daily LFT, and is symptom free. Should a member of staff test positive, contact tracing is conducted through our Human Resources department so that immediate action can be taken within the hospital.

Table 1 provides the data for testing and confirmed cases of Covid-19 within the patient population in TSH over the past six months.

Month	April	May	June	July	August	Sept
Total Tests	11	16	19	17	25	81
Asymptomatic tests	11	15	17	13	2	73
Positive results	0	0	0	0	2	4
Negative results	11	16	19	17	23	77

Table 1: Patient Tests and Results April – Sept 2021

During October and at time of reporting, there have been 35 patient Covid-19 tests undertaken. One was to support a new admission into the hospital as well and one to support transfer to University Hospital Wishaw for care (unrelated to Covid-19).

Three tests were due to patients being symptomatic and 30 tests were part of contact tracing after positive cases. In total to date, 32 tests were negative with three patients testing positive.

Table 2 below provides the updated positon on staff testing and incidence of Covid-19

	Number	% of Total Staff population (n=650)
Staff tests	487	75%
Positive test results	92	14%
Negative test results	382	59%

Table 2- staff testing and results to 18 October 2021.

As part of mass testing 124 staff were PCR tested. 88 of these were performed on site by a mobile testing unit with a further 36 were tested in national centres. At the time of reporting 121 results were negative and two positive with one result outstanding.

3.4 Response to Outbreaks

On 28 August and then on 3 September, positive COVID cases were identified within two wards on two different Hubs (Mull 1 and Iona 3). This affected two patients in Mull and four patients in Iona 3. This led to these wards and affected patients being managed in isolation, to prevent further spread within the hospital. A Problem Assessment Group was set up in response to the two outbreaks to manage the initial response; and this was followed by Incident Management Team meetings. This included senior colleagues from the national ARHAI Team, the Infection Control Consultant from NHS Lanarkshire as well as colleagues from NHS Lanarkshire Test and Protect. These incidents were successfully managed through this process with no further spread in the Hospital beyond these cases. Two of the patients affected in Iona 3 required care in University Hospital Wishaw due to deteriorating physical health as a consequence of COVID. These patients recovered sufficiently and were safely transferred back to the State Hospital.

On 12 October, a Problem Assessment Group was set up in response to the two outbreaks to manage the initial response; and this was followed by an Incident Management Team being stood up on 13 October. This included senior colleagues from Scottish Government Incident Management, Public Health, the Infection Control Consultant from NHS Lanarkshire as well as from Test and Protect. This team will lead the response until both incidents have been formally closed.

Lewis 1 Ward: Initially, three patients and one staff member tested positive for Covid-19. The three patients have experienced mild symptoms and remain in isolation under clinical observation. All other patients within Lewis 1 ward were tested, and the results were negative. PCR testing and contact tracing of the patients who had tested positive was carried out, and patients identified as close contacts were isolated to their bedrooms. In total 22 patients were identified as close contacts and all tested negative. These patients were re-tested on Monday 18 October, and again all tested negative. Local contact tracing was carried out through the Human Resources team for staff contacts.

From the mass testing exercise, there have been two members of staff (both from Lewis 1) who have been confirmed as positive. One case may be unrelated as the member of staff had a previous positive test within the last 90 days. It was thought that this case may simply be residual infection.

At time of reporting, the end of the isolation period within Lewis 1 is 28 October 2021, should there be no further cases.

Security Department: Six members of staff within the Security Department tested positive for Covid-19 and the Human Resources Team carried out local contact tracing to identify any close contacts. On 19 October, a further member of staff within the department tested positive. They had been on annual leave, and it was concluded that this was likely to have been part of the original outbreak rather than a new incident. The incident within the Security Department was formally closed on by the Incident Management Team on 19 October 2021

Patient and staff testing:
PCR testing for patients was fast tracked, and a mobile testing unit was brought on site on Thursday 14 October 2021 to carry out mass PCR testing for staff identified as contacts of positive cases (both in terms of Lewis 1 and Security staff) as well as for staff who may have been concerned. Members of staff who returned a negative PCR were advised to continue to carry out daily Lateral Flow Device testing for a period of ten days from their test date

Review of Environmental/ Existing Infection Control Practice:
The IMT reviewed the environmental factors to consider whether additional action was required. They concluded that there was a high standard of infection control practice and cleaning measures in already in place, and that no further deep clean activity in addition to the standard practise was required.

It was agreed that communication to raise general awareness of infection control compliance should be sent to staff.

3.5 Covid-19 Vaccination Programme

TSH has undertaken a programme of vaccination for both patients and staff as part of the national roll out of the Covid–19 vaccination programme. All eligible staff were offered the vaccine and 88% of staff in this cohort have been fully vaccinated, with a small cohort declining the vaccine. A programme of booster vaccinations for staff is now underway having commenced on 19 October. This has been managed separately to the roll out of the seasonal flu vaccine for staff which has also been underway during October.

Measurement of the data in regard to patient vaccination changes over time to reflect patient flow through admissions in and transfers out of the hospital. All newly admitted patients are

offered two doses of the vaccination, if they have not already received third and uptake remains high.

The identified vulnerable patient group, who were first to receive the vaccine within TSH, are now eligible for a booster and will be vaccinated in the week commencing 25 October. A programme to commence booster vaccinations for the rest of the patient cohort will be commenced at the end of November. Uptake will be monitored and as previously, patients will be supported and advised on the importance of vaccination.

3.6 Test and Protect

Self-testing by staff by LFD is on a voluntary basis, and all staff are encouraged to undertake and register their test results on a twice weekly basis. However, reporting rates remain low across NHS Scotland with TSH reporting a rate of 9% during October 2021 compared to a national rate of 13% (reported as a percentage of the expected overall number of tests). Work is continuing through internal communications as well as in partnership with staff side colleagues to continue to encourage staff to report LFD testing twice-weekly.

In addition, TSH requires that all contractors coming on site undertake LFD testing. Auditing of this has continued and no issues have been noted with the uptake and management of this control measure.

3.7 Clinical Care Guidance for COVID-19 patients

There has been no change to this guidance to date. On 20 October, CMT reviewed contingency planning for the delivery of enhanced care for patients on site for symptoms of Covid-19, in the context of pressures on service delivery in NHS Scotland in the winter period. This recognises the ongoing developments in medical care for Covid-19 to ensure that planning is in place for appropriate and safe care. This would only be should it not be possible to transfer a patient to acute care.

The Medical Director is liaising with NHS Lanarkshire to establish what medical care is now considered to be both safe and feasible within a TSH medical ward. This will return to CMT in early November for final decision-making on whether planning should be put into place to stand up the medical ward within TSH.

3.8 Personal Protective Equipment

There has been no change to this position, with no issues with stock availability on site. TSH continues to be linked with National Services Scotland (NSS) through procurement. To date, there have been no issues with stock availability on site. The programme to re-fit clinical staff with validated FFP3 masks, has continued with no issues reported.

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

3.9 Patient Flow

TSH continues to be linked in collaborative work and contingency planning with medium and low security care providers including admission to, and transfer between, secure mental health services, suspension of detention and preparation for moving into the community. This is

focussed on the transfer of those patients assessed as ready to move to another setting as soon as possible,

On 20 October, the CMT reviewed further contingency planning for TSH, recognising the potential risk of systemic delays. CMT has commissioned an assessment of available options in order to score and develop a local contingency plan. This includes options to change the use of the existing estate, ward management, and an admissions waiting list. This will return to CMT in November for review and recommendations on the route forward.

The following table outlines the high level position from 1 August to 30 September 2021.

	MMI	LD	Total
Bed Complement	128	12	140
Staffed Beds	108	12	120
Admissions	3	1	4
Discharges / Transfers	1	0	1
Average Bed Occupancy: Available beds/All beds			97% / 82.8%

Table 3: Patient flow 1 June to 31 July 2021

3.10 Virtual and In Person Visiting

In Person Visiting

In line with national guidance, visiting in person recommenced at TSH on 26 April 2021. This continues to be supported through the Family Centre, as well as some on ward visit, depending on the clinical status of the individual patient. Visitors are encouraged to undertake Lateral Flow Device (LFD) Testing, on a voluntary basis to help support infection control within the hospital. Some patients may not have designated visitors, and additional support for these patients is in place through volunteer visitors.

The CMT commissioned a clinically led review on 17 August 2021, to consider the optimal visiting model, and this is due to be completed in November 2021.

Virtual Visiting

This service remains in place and use has remained consistent. Additionally, work is progressing to facilitate a ''Proof of Concept'' trial within the hospital. This is to allow full consideration of an alternative solution to video-conferencing, which is in use elsewhere in other secure organisations across the U.K. and which may bring additional capability to control and manage video calls locally. However, the information governance aspects of this are stringent and are being finalised before the trial can commence. An update will return to the Board in December 2021.

3.11 Workforce

3.11.1 Attendance Management

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

3.11.2 Planning for Extreme Loss of Staff

The Extreme Loss of Staff Plan for TSH, which was developed at the start of the pandemic, in response to a significant threat to business continuity, is refreshed regularly with local data and knowledge.

3.11.3 Staff Recruitment

Human Resources take forward the recruitment process for all confirmed positions with appointments made across a range of disciplines.

There are currently 37 posts actively moving through the recruitment process. This is focussed on Nursing and Allied Health professionals; but also includes eHealth, Medical, Psychology, Security, Human Resources, Housekeeping and Catering.

Since the date of the last Board meeting, recruitment activity has concluded for posts within Ward Based Nursing, Skye Centre, Security, Human Resources, Maintenance and Learning and Development.

There is ongoing recruitment within nursing looking at the coming six-month period, anticipating staff retirals.

3.11.4 Staff Wellbeing

The Staff Wellbeing Centre continues to be used every day with staff utilising it for tea breaks and lunch breaks as well as making use of massage equipment. The space available can be used as a meeting point when possible – this had included the QI Café as well as dedicated Short Life Working Groups.

It is also being used for special events if this has been possible within infection control guidelines. Some examples of this recently have been participating in the MacMillan Coffee Morning on 24 September, as well an event to promote AHPs Day 2021 on 14 and 15 October. This event included refreshments and home baking and a raffle along with the promotion of the AHP role.

Two part-time Wellbeing Advisors have been appointed – both advisors have now commenced their work in this role. Pastoral Support will be provided through agreement with NHS Lanarkshire, and this post has now been advertised.

A draft Wellbeing Strategy has been completed and will be reviewed at the HR and Wellbeing Group meeting at its November meeting. An Action Plan will be established to frame the implementation of the strategy.

Regular network meetings have been established with Human Resources and Occupational Health established to further embed joined up working to support wellbeing.

Staff Wellbeing has also been promoted through special bulletins issued to all staff during this time. This has included promotion of the Workforce Specialist Service which provides confidential advice to regulated professionals working in health and social work or social care in Scotland.

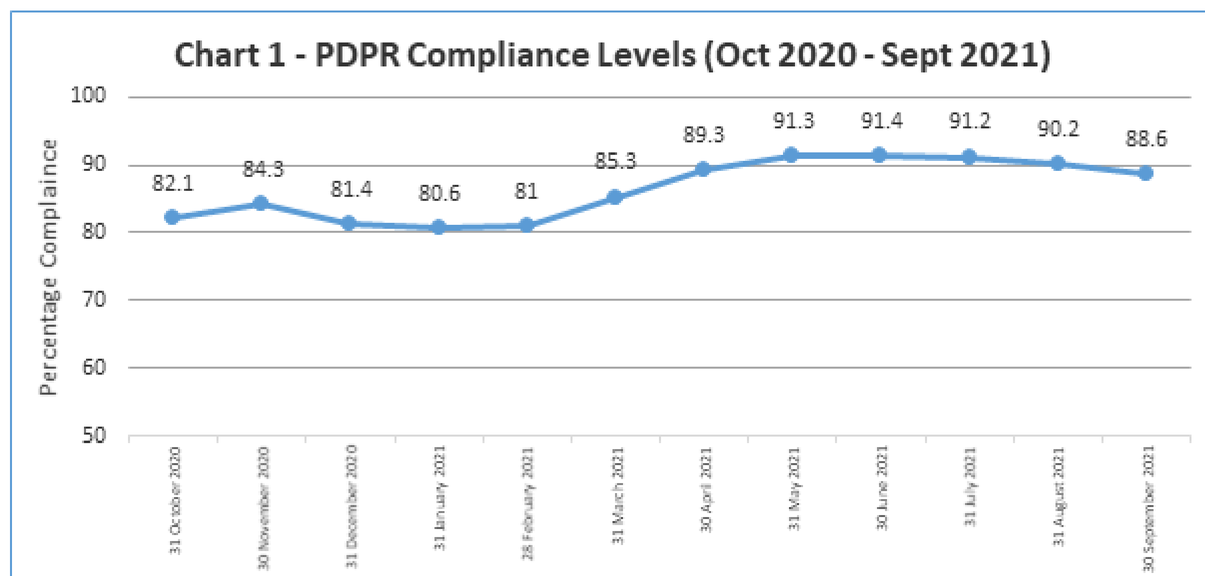
In September a "Self-Care Calendar" was promoted to highlight that Self-care is essential and shouldn't be seen as selfish or a luxury only. World Mental Health Day was promoted on 10 October and this also provided a range of support mechanisms for staff.

3.11.5 Personal Development Planning and Review (PDPR) compliance

As at 30 September 2021:

- The total number of current (i.e. live) reviews was 537 (88.6%).
- A total of 53 staff (8.8%) had an out-of-date PDPR (i.e. the annual review meeting is overdue).
- A further 16 staff (2.6%) had not had a PDPR meeting. Staff in this group are predominantly new staff with an initial set-up review meeting overdue.

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



As indicated in Chart 1, PDPR compliance levels have shown a slight downward trajectory during Quarter 2. Staff absence and staffing resource pressures have been significant over recent months and this is likely to have been a key contributory factor in this reduction in compliance.

3.12 Communication

Staff Bulletins provide communication throughout the organisation, providing high level feedback to staff about national developments, as well as more local updates for TSH. This period has included a period of resourcing difficulty due to staff absence within Communications; and additional support to this function has been provided through the Board Secretary and the

Corporate Services Team. During October, this has focussed on ensuring urgent communications have been issued to all staff on the management of the Covid-19 outbreaks within the hospital.

3.13 Digital Technology

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

4 RECOMMENDATION

The Board is invited to:

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

2. To advise whether any additional reporting is required to be presented.

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 of the NHS Board during Covid 1-19 emergency response ensuring the NHS Board received detailed reporting across directorate areas.
Workforce Implications	Considered in this report – noting staff wellbeing, staff appraisal arrangements and recruitment.
Financial Implications	Financial implications outlined within a separate dedicated Financial report related to Covid-19 presented at same Board meeting
Route to Board Which groups were involved in contributing to the paper and recommendations.	Board requested for each meeting
Risk Assessment (Outline any significant risks and associated mitigation)	Fully outlined and considered in the report
Assessment of Impact on Stakeholder Experience	Fully outlined and considered in the report: staff patients, carers, volunteers
Equality Impact Assessment	Not required for this report as monitoring summary report.
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	There are no identified impacts.
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One X There are no privacy implications. ☐ There are privacy implications, but full DPIA not needed ☐ There are privacy implications , full DPIA included.

NHS SCOTLAND

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	28 October 2021
Agenda Item:	Item No. 7b
Sponsoring Director:	Director of Finance and eHealth
Author(s):	Director of Finance and eHealth
Title of Report:	Financial Governance – Covid-19
Purpose of Report:	For Noting

1 SITUATION

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

2 BACKGROUND

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

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

For 2021/22, on a similar timing basis to 2020/21, an initial report – for the three-month period April-June (Q1) – was submitted to SG in July, with a similar report for July-September (Q2) being prepared in October – both incorporating a forecast of expected costs for the remainder of the financial year. This is on the basis that Covid-related costs while initially expected to impact on Q1 and Q2 are now being scheduled to the year-end – and discussions are due imminently with SG to address the settlement for Q3, Q4 and beyond if necessary into 2022/23 et seq. (Currently a requirement identified nationally by territorial and other boards).

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

3 ASSESSMENT - FINANCE

3.1 Financial Governance and SG allocation

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

While it was initially anticipated that Covid costs for 2021/22 would be reported monthly to SG for allocation agreement in the same way as Q3 and Q4 of 2020/21, it has now been indicated that this will not be the process. Instead, we have reported Covid costs through Q1/2, with allocations therefrom now agreed in a similar way to that which was applied in August 2021 for the early months of the Covid crisis, and Q3/4 is now to be determined (expected October/November 2021).

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

While our budget for 2021/22 was initially drafted with an assumption that Covid-related costs will continue though Q1 and Q2 only, we are monitoring this position on a month-by-month basis for reporting and forecasting to ensure all relevant costs are included for consideration in the new year's Covid allocation process, and applying as appropriate to Q3 and Q4.

3.2 Covid19 specific costs

Continuing in the main from 2020/21, the principal revenue costs incurred in relation to Covid19 in 2021/22, as submitted in the Board's Q1&2 return and Q2 forecast are as undernoted.

i. Overtime costs Q1&2 £100k – additional overtime incurred each month due principally to the increased levels of staff absence arising from Covid absences (classified as special leave), together with an element of high level clinical demands. (This is principally re Nursing, but includes £10k re Infection control and Security).

ii. Student nursing recruitment £300k – these costs are to be confirmed with SG with regard to the correct allocation of costs of additional student nurses to confirm if these are to be funded directly through the Covid funding as in 2020/21.

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

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

v. Estates/facilities costs £40k – including the requirement for additional food container for the appropriate provision of safe catering.

vi. "Dual running" / Infection Control staff costs – £35k – relating to Covid support posts ongoing.

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

3.3 Covid19 costs – vaccinations programme

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

4 RECOMMENDATION

The Board is asked to note this report

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Monitoring of Financial Position and Digital developments
Workforce Implications	No workforce implications – for information only
Financial Implications	No financial implications – for information only
Route to SG/Board/SMT/Partnership Forum Which groups were involved in contributing to the paper and recommendations.	Finance and eHealth Director
Risk Assessment (Outline any significant risks and associated mitigation)	None identified
Assessment of Impact on Stakeholder Experience	None identified
Equality Impact Assessment	No implications
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	None identified
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One √ There are no privacy implications. ☐ There are privacy implications, but full DPIA not needed. ☐ There are privacy implications, full DPIA included.

NHS SCOTLAND

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	28 October 2021
Agenda Reference:	Item No: 8
Sponsoring Director:	Medical Director
Author(s):	Head of Corporate Planning and Business Support/ Consultant Psychiatrist
Title of Report:	Clinical Model
Purpose of Report:	For Decision

1 SITUATION

Planning for Implementation of the Clinical Model was in an advanced stage prior to the Coronavirus pandemic. Work was paused in March 2020. In preparation for planning for restart, and move towards implementation, of the Clinical Model the CMT agreed at its June 2021 meeting to consider the current context, previous work carried out and what the future conditions would require prior to any restart.

2 BACKGROUND

The clinical care model describes the way The State Hospital (TSH) provides high secure services to patients with a mental disorder many of whom have offended. The need to review the Clinical Care Model arose from issues raised through a staff engagement exercise which focused on readiness to change. In May 2021, a presentation was given to the Board outlining the factors that would have to be considered as part of restarting this piece of work. These included:

- Reviewing the progress made in 2019/20 in planning for implementation of the Clinical Model and considering what aspects continue to be fit for purpose and where changes are required
- Identifying any adjustments required to the model in light of TSH experience of working through Covid 19 pandemic, the interim Clinical Operational Policy and the recommendations from the Barron Review
- Reviewing current patient population to align with new clinical model.
- Considering the financial aspects of the model and reviewing if this continues to be achievable in financial plan 2021/22

Patient mapping exercise

A patient mapping exercise was carried out between 15 and 30 June 2021. The Clinical Model of two Admission and Assessment, four Treatment and Recovery, two Transition and two

Intellectual Disability (ID) wards was a good fit for current patient population when mapped across, however crucially TSH had at that time 100 Major Mental illness (MMI) patients and only 96 MMI beds in the new model. The ID population currently sits at 14, the new model would have these patients dispersed across two wards. As the patient population for MMI exceeds the beds available in the new model, adjustments and options for progressing the model are currently being considered.

Consideration of range of options from the mapping

The options below were shared and discussed with staff groups through meetings (the Corporate Management Team (CMT), Organisational Management Team, Clinical Governance Group) in July and August 2021.

Option 1
TSH fully explores the contingencies and processes that would be required to be in place to enable progression to the new clinical model.

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

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

Option 3
TSH plan to progress with a hybrid Clinical Model with two Admission and Assessment, one ID, five Treatment and Recovery and two Transition wards until the MMI patient number reduce and second ID ward is reconfigured from the fifth Treatment and Recovery ward.

3 ASSESSMENT

Initial feedback from consideration of Clinical Model options

- The Clinical Model of Admission and Assessment, Treatment and Recovery, Transition and ID wards continued to be popular with both staff and patients.
- There are differences of opinion about the number of Admission and Assessment wards required to ensure safe patient mix, particularly in regards to disassociations required between patients.
- The ID service continue to support preferred position of two ID wards with patients spread across these.
- The sequencing of the implementation of the Clinical Model could be planned in a way that the Transition wards are first to be established, thus allowing patients who are abler to benefit from care within these wards to be moved into them prior to transfer from TSH to next destination. This would allow for the potential to free up a small number of staff from these wards. This would also provide a benefit of enabling learning from one movement prior to progressing to the next phase of Clinical Model implementation.
- The current status quo is not the preferred option for staff or patients

Areas of consideration to support planning for implementation include:
Ward Types and Allocations

- Ward types need further review and updating to ensure they are contemporary, and reflect any relevant learning and development from experience of Covid.

- Desk top exercise with current patient population to identify issues of disassociation and support decision making regarding the patients for 'transition wards' and patients for 'admission and assessment' wards.
- Decision to be reached on number of admission and assessment wards. Current plan had been for two wards but in recent discussion there has been some support for three wards to manage disassociations.
- The issue of whether the ID service can move to two wards whilst the MMI patient population is in excess of 96 patients needs to be resolved.
- The criteria and pathways for movement from each ward type need to be developed

Implementation

- Movement of patients and staff due to Covid considerations will need to be done in a Covid secure way – thus supporting a staggered gradual phased approach
- The process and overall governance of the project implementation need to be agreed including timeframe

Forensic System

The wider system issues of flow from high to medium secure units should be addressed across the Forensic Network

Next steps

The CMT, at its meeting on 15 September 2021, considered the above issues and agreed the following six steps to provide further insights and inform planning and decision making.

1. **Revisit the mapping exercise carried out in June and explore the disassociations for patients to identify and analyse trend data. Utilise the desktop exercise and place real patients into wards to understand any issues around dissociation.**

Action – analysis of data

Timeframe – complete by end October 2021

Outcome – Clarity on patient placement in ward types and inform decision on number of admission and assessment wards required. Clarity on the trend data for disassociations and the impact of patient disassociations on the Clinical Model.

2. **The emerging views from staff, patient and carers groups to feed into consideration of the options for progressing the model.**

A: Staff

Action – Discussion on options and issues to be held across the range of staff group meetings in October and November, feedback collated.

Timeframe – collate feedback by end of November 2021

Outcome – Staff groups will have had opportunity to reconsider the Clinical Model and feedback on this. Clarity on issues to consider when moving to implementation Staff engaged in process.

B: Patient and carer engagement

Action - Initial engagement with patients has commenced and will continue with aim of raining awareness of the clinical model and check in on what patient expectations are.

Timeframe – further engagement with patients and carers once definitive clinical model and timeframes for implementation agreed

Outcome – Patients and carers aware of the Clinical Model and have given some consideration to what this means to them.

3. **Agreement on how the Clinical Model work interacts with the Activity QI work to ensure collaboration and alignment of activity.**

Action – CMT to ensure alignment and discuss in detail how these pieces of work link and add value to each other. When Operational Group established ensure that each ward type has activity pathway guidance written into the ward clinical guidance.

Timeframe – ongoing as projects progress

Outcome – the Clinical Model and Activity QI project align and support redesign of activity with a redesigned ward structure

4. **Agreement on governance and implementation group structure to support project management and governance. Clinical Guidance needs to be agreed prior to movement**.

Action – proposed governance and implementation mechanism:

- Strategic oversight sits with CMT with the Clinical Model as an agenda item for regular oversight.
- Governance through Clinical Governance Group,
- Operational Group (CMOG) – Short Life Operational Group to be established with the responsibility and authority to plan and implement the change, monitor impact and report back to the Clinical Governance Group and the CMT.

Outcome – clarity on how the process of moving into the new Clinical Model implementation will be operationalised. Clarity on roles and responsibilities for this, Clarity on phasing and timescales. Clarity on communication and decision making routes. Clarity on how the model and activity work coalesce. Clarity on ongoing process of patient, carer, stakeholder engagement

Timeframe – To be agreed

5. **Consideration of financial resourcing and revenue implications of the new model are revisited. This step requires confirmation of the proposed model**

Action – Review of the financial and resourcing implication of agreed model

Timeframe – To take place once Step 1 complete and definitive proposed new clinical model agreed

Outcome – contemporary understanding of the financial and risk assessment of the new model

6. **Wider system considerations – Await feedback from Scottish Government Mental Health Directorate on the Forensic Networks Draft Action Plan to create better flow and movement of patients through the forensic estate.**

Action – Forensic Network presented report and plan to Scottish Government on 28 September 2021. Response received with three immediate actions to be taken forward.

Timeframe - Await further feedback from Forensic Network meeting with Scottish Government on 26 October 2021.

Outcome – insight into Scottish Government plans to and associated actions to create better flow through the system. Potential to impact positively on the Clinical Model is patients who are ready for transfer can move on.

4 RECOMMENDATION

The Board is asked to:

- note the progress made and proposed next steps on the restart of the Clinical Model.
- note the intention for wider staff discussion and engagement as options are further considered.
- Note the governance structure outlined.
- Consider and decide future oversight and governance through the Board and its committee structure. Members are asked to consider if oversight should be led through the Clinical Governance Committee and/or reporting should be made directly to the Board.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Supports the implementation of the Clinical Model
Workforce Implications	Some of the actions may result in additional workforce resources being required
Financial Implications	As above
Route To The Board Which groups were involved in contributing to the paper and recommendations	Requested by the Board as an update report, reporting led through the CMT
Risk Assessment (Outline any significant risks and associated mitigation)	Risk that the current patient population will not fit into the clinical model
Assessment of Impact on Stakeholder Experience	Stakeholder experience may by impacted due to the new model being unable to be implemented at this time
Equality Impact Assessment	An EQIA has been completed for this project in 2020
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do)	n/a
Data Protection Impact Assessment (DPIA) See IG 16	Tick One √ There are no privacy implications. ☐ There are privacy implications, but full DPIA not needed ☐ There are privacy implications, full DPIA included

Paper No. 21/74

NHS SCOTLAND

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	28 October 2021
Agenda Reference:	Item No: 9
Sponsoring Director:	Director of Nursing and Operations
Author(s):	Social Work Team Leader / Director of Nursing and Operations
Title of Report:	Corporate Parenting Plan 2021 - 2023
Purpose of Report:	For Decision

1 SITUATION

On 1st April 2015, The State Hospital on behalf of the Scottish Ministers joined many other public bodies in Scotland to become a national corporate parent under the Children and Young People (Scotland) Act 2014. Part 9 (Corporate Parenting) of the Children and Young People (Scotland) Act 2014 places responsibilities on The State Hospital to improve the lives and futures of Scotland's looked after children, young people and care leavers.

2 BACKGROUND

The Children and Young People (Scotland) Act 2014 was passed in March 2014 and is a major piece of legislation which introduces significant changes to the planning, operation and delivery of children's services in Scotland. The Act largely adds to or amends previous statutes which have set out the legal framework for children's services.

Section 56 of the Children and Young People (Scotland) Act 2014 identifies The State Hospitals Board for Scotland as one of 24 'Corporate Parents', which also includes all NHS boards, all local authorities, and our colleagues at the Care Inspectorate and Mental Welfare Commission, amongst others. Our duties as a Corporate Parent are set out in Part 9 of the Act, and we have a number of other responsibilities under additional Parts of the legislation.

These duties are not the responsibility of a single named individual, post holder or part of our service. They should be delivered jointly as an organisation, and embedded into the way we work. Evidence shows that care experienced young people have poorer health and wellbeing outcomes than other children and young people. Part of our responsibility as a Corporate Parent involves working to ensure these outcomes improve.

As a Corporate Parent, The State Hospital has a responsibility to set out how we will satisfy our resulting duties and functions. This Plan will outline these duties and explain what actions we will take and how we will monitor our performance.

3 ASSESSMENT

The purpose of the action plan is to set out the actions The State Hospital will undertake up to April 2023 in order to fulfill our statutory duties as a Corporate Parent. For the purposes of this plan,

looked after and accommodated children and young people and care leavers will be referred to as young people.

The aims of the plan are:

- To ensure The State Hospital fulfils its duties in a way which is consistent with its functions as a National Health Board.
- To make all State Hospital staff aware that the organisation is a Corporate Parent with resultant duties to fulfill to present a set of proposed actions which The State Hospital will undertake and report on to Scottish Government.
- To ensure that we uphold the rights and safeguard the wellbeing of young people in our care.
- To promote the physical, emotional, spiritual, social and educational wellbeing of young people in our care.

Our performance as a corporate parent has been monitored via the Child and Adult Protection Forum which meets on a 6 weekly basis and reviews the admission of care experienced young people to ensure that this information is appropriately recorded and shared with the relevant clinical teams. On an annual basis, the Child and Adult Protection Forum provides a report to the board which incorporates our corporate parenting responsibilities and any associated issues and areas for improvement. Whilst these mechanisms are in place, it is the case that our experience in this area has been limited due to the extremely low numbers of patients to whom the responsibilities apply. In the first two years of our current plan we had one patient to whom the provisions applied. As such, identification of trends, performance and indicators is somewhat limited as a consequence. However, we remain committed to ensuring that corporate parenting remains embedded within our performance reviews and hope to further develop our practice as our patient demographics evolve.

4 RECOMMENDATION

The Board are invited to note the content of The State Hospital Corporate Parenting Plan 2021 – 2023, support its continued monitoring and review via the Child and Adult Protection Forum and support the submission of this document to the Scottish Government Corporate Parenting Team.

Paper No. 21/74

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Demonstrates compliance with Part 9 (Corporate Parenting) of the Children and Young People (Scotland) Act 2014
Workforce Implications	None identified
Financial Implications	None identified
Which groups were involved in contributing to the paper and recommendations.	Child and Adult Protection Forum
Risk Assessment (Outline any significant risks and associated mitigation)	Completion of the Corporate Parenting Plan ensures compliance with statutory obligations.
Assessment of Impact on Stakeholder Experience	The plan provides a mechanism to further support care experienced young people within The State Hospital.
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)	Supports the principles of this legislation.
Data Protection Impact Assessment (DPIA) See IG 16	Tick One **x** There are no privacy implications. ☐ There are privacy implications, but full DPIA not needed ☐ There are privacy implications, full DPIA included

NHS SCOTLAND

The State Hospitals Board for Scotland

Corporate Parenting Plan

2021–2023

October 2021

Introduction

On 1st April 2015, The State Hospital on behalf of the Scottish Ministers joined many other public bodies in Scotland to become a national corporate parent under the Children and Young People (Scotland) Act 2014. Part 9 (Corporate Parenting) of the Children and Young People (Scotland) Act 2014 places responsibilities on The State Hospital to improve the lives and futures of Scotland's looked after children, young people and care leavers. In practice, this means we must listen to the needs, fears, challenges and wishes of these groups and be proactive in our approach to improve outcomes and wellbeing.

This is the second Corporate Parenting Plan for The State Hospital and illustrates how the organisation has performed in relation to the objectives of the previous plan and sets out how the organisation will deliver its statutory obligations as Corporate Parent for the next three year period. In developing the Plan valuable contributions were made by partner agencies including Lanarkshire Child Protection Committee and the Centre Excellence for Looked after Children in Scotland (CELCIS). CELCIS have been specifically commissioned by Scottish Government to support Corporate Parents. We have engaged with the Scottish Government Corporate Parenting Team and participated in their 2021 survey which provided an opportunity to reflect on our journey, performance and learning as a Corporate Parent between 2018 and 2020. We have also had the opportunity to review the Corporate Parenting Plans of many of the public bodies in Scotland.

Our ambition is that this Corporate Parenting Plan clearly describes our contribution to meeting the specific care needs of young people in our service, and in doing so, helps improve the overall health and wellbeing outcomes for this group.

Mark Richards – Director of Nursing and AHPs

David Hamilton – Social Work Manager

Part 1 – Context

A national service

The State Hospital is the national high secure mental health resource for Scotland and Northern Ireland. The principle aim of the Hospital is to provide high quality forensic mental health assessment, care, treatment and rehabilitation for male patients who require a high secure environment.

The Hospital has up to 140 beds available, and provides a service to people with mental illness and intellectual disabilities. Our model of care is based on human rights principles and adopts a holistic, person centred approach. Each patient is cared for by a multi-disciplinary clinical team comprising highly skilled professional staff in the fields of psychiatry, nursing, social work, allied health professionals, pharmacy, psychology, activity and recreation, and security.

The NHS Scotland Healthcare Quality ambitions are at the core of service delivery, with a focus on delivery of safe, effective and person centred care.

Patients are admitted to the Hospital under the Mental Health (Care and Treatment) Act 2003 and other related legislation because of their dangerous, violent or criminal propensities. Patients without convictions will have displayed significantly aggressive behaviour, normally including violence. Most of the patients in the Hospital are 'restricted' patients who fall under the jurisdiction of Scottish Ministers. These are patients who are subject to special restrictions without limit of time in order to protect the public from serious harm.

Corporate Parenting

The Children and Young People (Scotland) Act 2014 was passed in March 2014 and is a major piece of legislation which introduces significant changes to the planning, operation and delivery of children's services in Scotland. The Act largely adds to or amends previous statutes which have set out the legal framework for children's services.

Section 56 of the Children and Young People (Scotland) Act 2014 identifies The State Hospitals Board for Scotland as one of 24 'Corporate Parents', which also includes all NHS boards, all local authorities, and our colleagues at the Care Inspectorate and Mental Welfare Commission, amongst others. Our duties as a Corporate Parent are set out in Part 9 of the Act, and we have a number of other responsibilities under additional Parts of the legislation.

These duties are not the responsibility of a single named individual, post holder or part of our service. They should be delivered jointly as an organisation, and embedded into the way we work. Evidence shows that care experienced young people have poorer health and wellbeing outcomes than other children and young people. Part of our responsibility as a Corporate Parent involves working to ensure these outcomes improve.

As a Corporate Parent, The State Hospital has a responsibility to set out how we will satisfy our resulting duties and functions. This Plan will outline these duties and explain what actions we will take and how we will monitor our performance.

Definition of a looked after child or young person

A child or young person is looked after when a Local Authority takes on some legal responsibility for their care and wellbeing. There are many legal routes through which a child can become looked after, including assistance in the provision of care for those with physical or mental disabilities. Corporate Parenting duties apply to children and young people who are looked after, regardless of the route by which they have found themselves in this position.

Children can be looked after in a number of settings, including foster care, kinship care, at home (by one or both parents) or in residential care homes. The Act applies to children and young people in all settings, including The State Hospital.

The Centre for Excellence for Looked after Children in Scotland (CELCIS) sets out the extent of Corporate Parenting duties as:

"Corporate parenting responsibilities' extend to all looked after children aged from birth to when they cease to be looked after. This includes children in foster care, residential care, secure care, 'looked after at home' (on Home Supervision Requirements) and those in formal kinship care. It also includes disabled children who are 'looked after' during a short break provision.

For State Hospital patients our corporate parenting responsibilities apply to care leavers who were looked after on their 16th birthday (or subsequently) up to and including the age of 25.

For the purposes of this strategy, the term '**care experienced young people**' will be used to describe Looked after Children and Young People and care leavers who are covered by this legislation.

Definition of a Corporate Parent

While there is a comprehensive definition of a 'Corporate Parent' provided in section 56 of the Children and Young People (Scotland) Act 2014, for the purposes of this Plan, the following definition, taken from the statutory guidance for part 9 of the Act**,** will be used. Corporate Parenting is:

"An organisation's performance of actions necessary to uphold the rights and safeguard the wellbeing of a looked after child or care leaver, and through which physical, emotional, spiritual, social and educational development is promoted."

The guidance sets out that the whole organisation is responsible for fulfilling the duties of a Corporate Parent, with implementation being led by senior management across all departments. It requires that staff at all levels in The State Hospital should be aware of the organisation's Corporate Parenting duties and recommends organisations review their induction and staff development processes in this light.

What are the duties of a Corporate Parent?

The duties of a Corporate Parent must be fulfilled for all looked after children and young people and care leavers. The Act sets out a series of six specific duties which Corporate Parents must fulfill. They are:

1. To be **alert** to matters which, or which might, adversely affect the wellbeing of children and young people to whom this part (i.e., part 9 of the Act) applies.
2. To **assess** the needs of those children and young people for services and support it provides.
3. To **promote** the interests of those children and young people.
4. To seek to provide those children and young people with **opportunities** to participate in activities designed to promote their wellbeing.
5. To take such action as it considers appropriate to help those children and young people to **access opportunities** it provides, and to make use of services, and **access support**, which it provides.
6. To take such other action as it considers appropriate for the purposes of **improving** the way in which it exercises its functions in relation to those children and young people.
   (Section 58, Children and Young People (Scotland) Act, 2014).

The State Hospital and Corporate Parenting

The State Hospital acknowledges that Corporate Parenting duties align with a number of our ambitions and priorities, and is strongly aligned with the Person Centred strand of the Healthcare Quality Ambitions of the NHS in Scotland.

Corporate Parenting seeks to enhance the wellbeing of care experienced young people and care leavers by removing barriers to opportunities which these demographics often face. Through this plan, we will seek to better understand the opportunities available to care experienced young people in our service, the barriers they may face in accessing them, and how we can work to improve their health and wellbeing.

We will seek to enhance the profile of care experienced young people, better understand how we are already working with this group, and develop a mechanism to record where people who use or come into contact with our service fall into this group.

We will seek to support our staff who are caring for our patients who are care experienced young people, to better understand the barriers facing them and develop models of practice that can best be employed to remove these barriers. We will also work in this area directly with our patients who have been care leavers themselves.

We will use our Person Centred Improvement Team and our Social Work partners to raise awareness of care experienced young people and care leavers, and what our responsibilities are as a national service.

Our aim is to support care experienced young people and care leavers to feel healthy and safe, and to support them to have the confidence needed to successfully navigate systems in place so they can take responsibility for their future wellbeing. We will do this by working in partnership with care experienced young people and care leavers, appropriate Corporate Parents, and other agencies who are able to support us in this aim. We will continue to work towards achieving this aim by ensuring that all State Hospital employees are aware of, and consider, the needs of care experienced young people and care leavers when delivering and developing services, and when working with the families and carers of our patients.

Although we are an adult service, we will discharge our corporate parenting responsibilities as they relate to care experienced young people in our care. We will also partner with other corporate parents to ensure that that any care experienced young people who visit our patients are appropriately supported.

How have we developed our Corporate Parenting Plan?

Through our local Child and Adult Protection Forum, we have looked at the duties set out by the Children and Young People (Scotland) Act 2014, beginning with the requirements set out under Part 9 on Corporate Parenting. These groups have executive, senior management and operational staff membership and report through our organisational governance structures.

We have taken advice from Policy Officers at the Scottish Government Corporate Parenting Team, and utilized resources from the Centre for Excellence for Looked After Children in Scotland (CELCIS), Getting It Right For Every Child (GIRFEC) and Who Cares? Scotland. We have consulted on our plan both internally, including staff, volunteers and those in leadership roles, and externally, with relevant interest groups supporting care experienced children and young people, people with an experience of care, third sector organisations such as Who Cares? Scotland, and fellow Corporate Parents, including our colleagues in NHSScotland, in social care and local authorities, and the statutory/regulation sector.

Part 2 – Action Plan

Purpose and aims of the action plan

The purpose of the action plan is to set out the actions The State Hospital will undertake up to April 2023 in order to fulfill our statutory duties as a Corporate Parent. For the purposes of this plan, looked after and accommodated children and young people and care leavers will be referred to as young people.

The aims of the plan are:

- To ensure The State Hospital fulfils its duties in a way which is consistent with its functions as a National Health Board.
- To make all State Hospital staff aware that the organisation is a Corporate Parent with resultant duties to fulfill to present a set of proposed actions which The State Hospital will undertake and report on to Scottish Government.
- To ensure that we uphold the rights and safeguard the wellbeing of young people in our care.
- To promote the physical, emotional, spiritual, social and educational wellbeing of young people in our care.

Governance and reporting

The Executive Lead for Corporate Parenting is the Director of Nursing and AHPs. While the Chief Executive, Chairman, and Board of The State Hospital will take leadership in this important area of our work, delivery of the plan will be supported by our Child and Adult Protection Forum, and progress reported through the Corporate Management Team. The State Hospital is committed to supporting all of our staff in meeting our duties and improving the way we work with, and anticipate the needs of, care experienced young people.

The State Hospitals Board for Scotland will update the Corporate Parenting Plan every three years in accordance with government guidance and will prepare an annual report of our progress in relation to our duties and actions.

Corporate parenting duties and actions

This plan will focus on our progress as a Corporate Parent over the past three years and will set out our aspirations as we continue to develop our knowledge and practice as a Corporate Parent.

Previous Objectives and Action Plan for 2021 - 2023:

1. To be alert to matters which, or which might, adversely affect the wellbeing of looked after children and care leavers

Action	Lead	Progress	Updated Action for 2021 - 2023
A Designated Person for Corporate Parenting will be appointed. The Designated Person will have a responsibility to ensure that any changes in legislation are implemented and to promote the interests of care experienced young people and care leavers, primarily through the delivery of this plan.	Director Of Nursing and AHPs	Achieved	Director of Nursing and AHPs has overall responsibility for Corporate Parenting and will continue to ensure that The State Hospital operates in accordance with legislative requirement. Ongoing monitoring of Corporate Parenting will take place via the Child and Adult Protection Forum.
Training will commence for staff across the organisation on March 2018. This will include the Senior Leadership Team and Board, to enable all staff to better understand our care experienced young people and care leaver population and their needs.	Social Work Manager	Achieved Corporate Parenting training is embedded via online learning and included in Keeping Children Safe courses.	Continue to deliver training and ensure that this is reflective of changes in legislation and practice.
We will ensure that all newly employed staff are aware of their specific responsibilities with regard to carrying out Corporate Parenting duties through our organisational induction programme.	Social Work Manager	Achieved Corporate Parenting forms part of the induction program for all new staff and is delivered as part of the Keeping Children Safe course to all new staff.	Continue to monitor uptake and completion of training via Learning and Development Team in conjunction with the Child and Adult Protection Forum.

In order to ensure that the organisation is alert to matters which have, or which might have, an adverse impact on the wellbeing of our young people, we have introduced Corporate Parenting training to all current and new staff, as part of their inductions, to ensure that everyone within the organisation has an awareness of our corporate parenting responsibilities and of the particular needs and challenges experienced by those who have been looked after. Corporate parenting is now incorporated into our Keeping Children Safe training delivery and associated online modules and participation in these learning events and modules is regularly monitored via the Learning Development Team and reported to the Child and Adult Protection Forum to ensure positive uptake.

Since 2018, the organisation has taken a number of steps to ensure we are alert to matters which might have an adverse impact on the wellbeing of children and young people. We have implemented measures to ensure that all those young people to whom corporate parenting responsibilities apply are identified upon admission with this being communicated via Medical Records department to the relevant Clinical Team. This information is now clearly recorded within the Care Program Approach (CPA) documentation and the Social Work team have specific regard to the corporate parenting status and associated needs within their reports which form part of the multi-disciplinary care and treatment plan. As such, the young person's care team is aware from an early stage that responsibilities apply and multi-disciplinary assessment is carried out within this context.

Corporate Parenting is now a feature of the Child and Adult Protection Forum and is monitored by this group on a regular basis with an annual report to the Board as part of our corporate governance. Given the particular nature of the hospital, the number of patients and the small proportion of these to whom corporate parenting responsibilities apply, we benefit from membership of the South Lanarkshire Child Protection Committee and liaison with partner agencies to help inform and develop our practice in this area.

The impact on our service in terms of staff participation in learning and development has improved the general level of awareness of our responsibilities as a corporate parent. We are now more alert to our role and aware of the importance of recognising the needs of the patients who are care experienced. These changes have been incorporated into existing structures with little disruption to our care model. As an organisation, we have had very low numbers of patients to whom the responsibilities apply and, therefore, the impact has been manageable thus far.

In terms of our young people, the changes we have implemented have ensured that their particular needs, as a consequence of their status as care experienced, are recognised at an early stage and incorporated fully into their assessment and care within the hospital.

2. To assess the needs of those children and young people for services and the support it provides

Action	Lead	Progress	Updated Action for 2021-2023
The State Hospital will undertake an analysis of its patient population in the context of care experienced young people and care leavers, to build a picture of need. This will inform the ongoing development Corporate Parenting Plan.	Medical Records	Patient population was analysed and relevant patients identified. Information was used to inform the Corporate Parenting Plan.	The Medical Records team will continue to undertake periodic review of the patient population and highlight any patients to whom these provisions apply. Experiences and identified needs will be incorporated into the new Corporate Parenting Plan.

Review our assessment processes to ensure we are able to consistently identify care experienced young people at the point of initial assessment.	Director of Nursing and AHPs	Patients are routinely screened on admission to identify any persons to whom Corporate Parenting responsibilities apply.	In addition to screening on admission, Medical Records and allocated Social Worker will review Corporate Parenting status for each patient by point of Admission CPA meeting to allow time for additional inquiries to be made. This will ensure a more robust approach going forward.

As a result of our changes to promote early identification of care experienced patients, the young person's care team is made aware from an early stage that corporate parenting responsibilities apply and multi-disciplinary assessment is carried out within this context. These assessments will encompass a holistic view of the young person including their mental well-being, their physical health, their social background including experience of poverty, educational attainment and exposure to traumatic events. Within the hospital, we are supported by the Trauma Informed Care Group who work to ensure that an understanding of trauma is embedded in our care model. In recognition of the increased risk of suicide and self-harm among looked after children and care leavers, each patient's risk in this respect is assessed with tailored measures of care and support provided accordingly. For those patients to whom corporate parenting responsibilities apply, contact is established with partner agencies to identify and access any existing corporate parenting plans to ensure partnership working, consistency with previously identified needs and to support transitional planning arrangements for those persons moving on from our service. There is now regular contact with partner agencies who have held corporate parenting responsibilities prior to the young person's admission to The State Hospital and ongoing engagement throughout their detention herein.

In recognition of the low levels of educational engagement and achievement which are prevalent among care leavers, all patients admitted to the hospital are offered support in relation to their educational needs. Information in relation to past educational attainment is gathered during the admission phase and concerns in relation to specific learning difficulties or intellectual disability are taken account of when developing rehabilitative plans. All patients are supported to take advantage of educational opportunities within the hospital, recognising that many have never completed any formal qualifications and some have specific literacy and numeracy needs. A tailored learning plan and relevant support is provided within the hospital with external educators supplementing the learning centre team to ensure that patients can pursue the level of learning commensurate with their abilities and aspirations – from basic literacy to degree level studies.

As an organisation, we are fortunate to have on-site access to a range of professional disciplines and rehabilitative opportunities which can be readily accessed in order to meet the needs of the young people in our care. All of our patients have an identified clinical team comprising Psychiatry, Nursing, Psychology, Social Work, Pharmacy, Dieticians, Security and Occupational Therapists. All patients have access to onsite physical health provision via GP and dentist services and promotion of physical health is a key aspect of our work in the hospital. Patients who require specialist health interventions are routinely referred to external health services and supported to engage with health professionals as required. We engage with partner agencies, local authorities, Police Scotland, the Scottish Prison Service and MAPPA as part of our admission, continuing care and discharge processes. This joined up approach ensures that identified needs are

routinely shared and should follow the young person as their recovery progresses and they prepare to move on from our service. Patients have routine access to independent advocacy services to help promote their rights and to ensure that they are meaningfully engaged in their care and treatment.

As an organisation we strive to deliver care in a safe and person centred way focusing on the specific needs of our individual patients. This approach is consistent with the aims of our corporate parenting plan and associated responsibilities. The key changes have been in ensuring that the specific needs of our care experienced young people are fully recognised and acted upon accordingly by our staff to ensure that they are in receipt of care, treatment and opportunities which are of benefit to them as individuals.

Young people are supported to engage in their recovery, to develop insight in respect of their needs and to participate in rehabilitative opportunities to maximise their potential during their time as patients within The State Hospital and as they progress to other services.

3. To promote the interests of those children and young people

Action	Lead	Progress	Updated Action for 2021 - 2023
Support staff to make changes to their own working practices and areas of work with the aim of improving outcomes for care experienced young people and care leavers, collaborating with corporate parenting partners to enable same.	Social Work Manager	Staff are in receipt of training and aware of Corporate Parenting responsibilities. Collaboration with Corporate Parenting partners is being achieved and is monitored via Social Work CPA reports.	Continue to ensure that Corporate Parenting issues are appropriately recorded and monitored.
Publish our Corporate Parenting Plan and associated updates.	Director Of Nursing and AHPs	The 2018 – 2020 Plan was published. Annual updates are prepared by the Child and Adult Protection Forum for scrutiny by the board.	2021 – 2023 Plan will be published following established governance protocols.

A key element of promoting the interests of young people in our care has been via the delivery of learning and developmental opportunities to staff in order to ensure that they are aware of our corporate parenting responsibilities in respect of the patients to whom these apply. We continue to monitor and review the identified needs and outcomes for the young people in our care via the CPA processes and our governance arrangements. Given the nature of our primary functions we are able to address and attempt to achieve positive outcomes for our patients in line with our corporate parenting goals. We actively promote a safe and stable environment for our care experienced young people, recognising the impact of their compulsory detention on their existing relationships and

offer support to maintain positive relationships with friends and family members via our Social Work service and the Person Centred Improvement Team. We strive to ensure consistency of care and recognise that experience of trauma can negatively impact the development of trusting relationships. Through the nomination of a nursing key worker and a consistent and transparent approach to developing care and treatment goals involving the patient, we seek to develop positive relationships with professionals based on trust. By ensuring access to independent advocacy services, legal representation and the Mental Welfare Commission, we seek to ensure that the rights of our care experienced young people are promoted and upheld. As previously stated, an emphasis on educational opportunities and development of life skills is a key component of our work within the hospital and aims to provide transferable life skills as young people progress from our care. By providing early assessment of physical and mental health, these issues are identified promptly and appropriate care options explored with the patient and health professionals. Where treatment is compulsorily given, governance arrangements ensure that this is carried out within the parameters of the relevant legislative frameworks.

The changes introduced since 2018 have enhanced our organisational understanding of, and approach to, our corporate parenting responsibilities and supported us to better identify, assess and promote the needs of those care experienced young people who come into our service. Given the nature of our primary functions and our resources in delivering these, the organisation has been able to adapt to the demands of corporate parenting and integrate these within our existing care and treatment framework.

4. To seek to provide looked after children and care leavers with opportunities to participate in activities designed to promote their wellbeing

Action	Lead	Progress	Updated Action
Assess and respond to the needs of our care experienced young people.	Social Work Manager	Care experienced young people receive a holistic assessment of need as part of the CPA process. Identified needs, objectives and outcomes are reviewed on a 6 monthly basis.	Monitor review documentation to ensure that Corporate Parenting issues are effectively addressed and recorded.

Provide care experienced young people with information on their rights.	Social Work Manager	Information regarding the rights of care experienced young people is provided by Social Work staff in conjunction with advocacy partners and Corporate Parenting partners.	Review information to ensure that it is provided in accessible formats.
Communicate and share best practice in relation to care experienced young people.	Social Work Manager	Information in relation to best practice regarding care experienced young people is fed into the CAPF and further disseminated to the wider staff group.	Continue to monitor information regarding best practice and ensure this is widely shared and incorporated into practice within The State Hospital.
Promote the needs of our care experienced young people with our corporate parenting partners.	Social Work Manager	Once identified, details of care experienced young people are shared with the relevant corporate parenting partner and a collaborative approach is sought to ensuring that their identified needs are met.	Monitor the involvement of corporate parenting partners and take steps to ensure partnership working to achieve best outcomes for care experienced young people.

As previously noted, the organisation has taken steps to identify the young people in our service to whom corporate parenting responsibilities at an early stage in their admission. Within the first 8 weeks of their admission, the young person will have been engaged in multi-disciplinary assessment of their needs and a care and treatment plan developed accordingly. Within the first two weeks of admission, each of the young people will have been offered support in terms of their educational needs and opportunities to promote well-being. Within The State Hospital, education and learning are widely recognised as important elements in promoting individual health and well-being. Key benefits associated with education and learning include improvements in self-confidence and self-esteem, personal development and self-fulfilment, enhanced life and social skills, social inclusion and behavioural change. The contribution of education in helping to address health inequalities is also well documented.

The following activities fall within the scope of patient learning within the State Hospital:

- Core skills development (i.e. literacy, language and numeracy)
- Open and distance learning (including further and higher education)
- Vocational training (e.g. horticulture, animal care, library and sports)
- ICT skill development
- Arts and crafts
- Personal and social development skills.

Patient learning services within the State Hospital are aimed at:

- Widening access and participation in learning and education
- Raising basic standards of literacy and numeracy
- Increasing skill levels and qualification attainment rates
- Improving the quality and range of learning opportunities available
- Reducing barriers to engagement in education and learning
- Enhancing integration of patient learning and the care and treatment planning process

For patients within the State Hospital, participation in education and learning can be an empowering and socialising process and can make a significant contribution to care, treatment and longer-term recovery and rehabilitation.

Patient learning programmes are mainly delivered within a range of activity centres. This includes: Patient Learning Centre (PLC); Patient Library; Gardens & Animal Assisted Therapy Centre; Sports & Fitness Centre and the Craft Centre. Outreach learning is also available as required.

Learning provision includes both accredited and non-certificated programmes and the hospital has 'approved centre' status with a number of qualification awarding bodies. This includes the Scottish Qualification Authority (SQA), the British Computer Society (BCS), the Royal Environmental Health Institute of Scotland (REHIS), and Sports Leaders UK.

Educational opportunities are fully encouraged and supported and are consistent with our commitments in terms of corporate parenting.

In relation to broader well-being issues, Nutritional Care Plans (NCP) are required for all patients as part of the Food, Fluid and Nutritional Care Standards (2014). Health and Wellbeing Plans (HWP) are developed for each of our young people in order to support their physical health and nutritional needs. We further undertake work to support the prevention and reduction of obesity within our patient group. These multidisciplinary plans are to support a patient's physical health, around their dietary intake, activity, personal care, psychological wellbeing and sleep. We aim to have a Health and Well-being Plan in place for all of our patients within 14 days of admission. These interventions should promote the well-being of our young people and provide them with transferable knowledge and skills as they progress in their recovery.

These initiatives aim to promote and support the recovery of all patients within our service. Staff are cognisant of their responsibilities to young people within our care and strive to ensure equality of access to opportunities from an early stage following admission. Regular communication with external corporate parenting partners ensures that they are aware of the opportunities available to our care experienced young people and they are provided with regular updates as to progress and future planning. This helps to support transitional plans and to ensure a degree of continuity when young people move on from our service.

The commitment to providing early intervention seeks to ensure that young people are not disadvantaged by their admission to The State Hospital and are involved from an early stage in assessment of their needs and the development of their care plans. Young people are encouraged to participate fully in their recovery and to access the opportunities available to them within the organisation.

5. ***To take action to help looked after children and care leavers:***

Access the opportunities provided, make use of our services, and access the support they provide

Action	Lead	Date	Updated Action
To support staff who work with care experienced young people to be aware of the rights and entitlements of this group, and to act as their advocates in accessing services.	Social Work Manager	Training has been delivered to increase staff awareness of their roles and responsibilities towards care experienced young people. Access to services and opportunities is provided within The State Hospital and in collaboration with partner agencies.	Monitor the experiences of care experienced young people to ensure equitable access to services.

As previously indicated, all patients from the point of admission to their eventual discharged are supported to be involved in their care, treatment and recovery. Support is offered in a person-centred manner with individual care and treatment plans being developed from an early stage in the admission process. Young people have identified key-workers who offer one to one support and monitor care plan outcomes which are routinely shared with the wider

clinical team on a weekly basis. Clinical teams are provided with weekly reports on patient engagement in physical activity and their access to rehabilitative and developmental opportunities. Where deficits are identified, opportunities and activities are identified and made available in a format best suited to meeting the needs of the individual. The provision of advocacy services further serves to ensure that the voices of our young people are heard and that their concerns and needs are responded to in a meaningful way. Governance arrangements monitor both the uptake and effectiveness of interventions and seek to promote the inclusion of all our patients in meaningful activity which will be of benefit to them.

As an organisation we strive to deliver care in a safe and person centred way focusing on the specific needs of our individual patients. This approach is consistent with the aims of our corporate parenting plan and associated responsibilities. The key changes have been in ensuring that the specific needs of our care experienced young people are fully recognised and acted upon accordingly by our staff to ensure that they are in receipt of care, treatment and opportunities which are of benefit to them as individuals.

Young people within our care are supported to be partners in their recovery and to have meaningful engagement with opportunities designed to promote their well-being and future development. Young people are encouraged to engage in learning and rehabilitative opportunities, in tandem with therapeutic interventions, to develop resilience and the life skills necessary to them as they progress from our service and work towards a return to the community.

6. To take any other action it considers appropriate for the purpose of improving the way it exercises its function in relation to looked after children and care leavers

Action	Lead	Progress	Updated Action
Engage with our care experienced young people to ensure that they have voice in shaping the actions that will be delivered.	Director of Nursing and AHPs	Opportunities exist to shape delivery of care and support via individual (Care Program Approach) and organizational (What Matters To You, Person Centred Improvement Team, Patient Partnership Group means.	Take steps to ensure that care experienced young people feel able to meaningfully contribute to service delivery and associated actions.
Provide a Corporate Parenting awareness raising session and supporting materials for Board Members.	Director of Nursing and AHPs	Information session and material provided to the board.	Further sessions to be provided following changes to Board membership.

Work in partnership with organizations focused on working with looked after children and young people and care leavers, to support the delivery of our action plan and associated work.	Social Work Manager	Liaison with relevant bodies contributed to development and delivery of the Corporate Parenting Plan and associated work.	Continue to work in partnership with relevant organisations to ensure our identified goals can be achieved.
Routinely monitor and report the outcomes of our corporate parenting plans on our care experienced young people, reporting this to the State Hospitals Board.	Director of Nursing and AHPs	The Child and Adult Protection Forum monitors outcomes and has provided annual progress reports to the Board.	Review the format for reporting to the Board to ensure SMART objectives and clear outcome monitoring.
Collaborate with other Corporate Parents to increase the value and impact of our corporate parenting activities.	Social Work Manager Director of Nursing and AHPs	Collaboration has taken place with other Corporate Parents to support the development of policy and practice.	Continue to engage with stakeholders to ensure best practice and positive outcomes for care experienced young people.

Our performance as a corporate parent has been monitored via the Child and Adult Protection Forum which meets on a 6 weekly basis and reviews the admission of care experienced young people to ensure that this information is appropriately recorded and shared with the relevant clinical teams. On an annual basis, the Child and Adult Protection Forum provides a report to the board which incorporates our corporate parenting responsibilities and any associated issues and areas for improvement. Whilst these mechanisms are in place, it is the case that our experience in this area has been limited due to the extremely low numbers of patients to whom the responsibilities apply. In the first two years of our current plan we had one patient to whom the provisions applied. As such, identification of trends, performance and indicators is somewhat limited as a consequence. However, we remain committed to ensuring that corporate parenting remains embedded within our performance reviews and hope to further develop our practice as our patient demographics evolve.

Useful sources of further information

Useful sources of further information

CELCIS (Centre for Excellence for Looked After Children in Scotland) *http://www.celcis.org/* , CELCIS | Support to implement corporate parenting duties

WhoCares? Scotland *http://www.whocaresscotland.org/*

South Lanarkshire Council's Corporate Parenting Sub Group - part of Integrating Children's Services

Skills Development Scotland *https://www.skillsdevelopmentscotland.co.uk/*

West of Scotland Care Leavers Forum

Scottish Government statistics *http://www.gov.scot/Topics/Statistics/Browse/Children/PubChildrenSocialWork*

Scottish Throughcare and Aftercare Forum

The Children and Young People (Scotland) Act 2014 http://www.legislation.gov.uk/asp/2014/8/contents/enacted

Wellbeing Indicators of Getting it Right for Every Child (GIRFEC): *http://www.gov.scot/Topics/People/Young-People/gettingitright/background/wellbeing*

Scottish Government Corporate Parenting Team, Children and Families Directorate

Paper No, 21/ 75

NHS SCOTLAND

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Board Meeting:	28 October 2021
Agenda Reference:	Item No: 10
Authors:	Educational Supervisor & Consultant Forensic Psychiatrist
Sponsoring Director:	Medical Director
Title of Report:	Medical Education Report
Purpose of Report:	For Noting

1 SITUATION

The General Medical Council (GMC) Quality Improvement Framework for Undergraduate and Postgraduate Medical Education in the UK sets out expectations for the governance of medical education and training. GMC standards specifically refer to Board governance and it is within this context that this report is being presented to the Board. This report covers the period 1st August 2020 to 31st July 2021.

2 BACKGROUND

The Educational Supervisor at The State Hospital (TSH) is responsible for postgraduate medical training while a Consultant Psychiatrist leads on issues relating to medical undergraduates.

The medical staff group within the State Hospital hold a 3 monthly training committee meeting which is chaired by the Educational Supervisor. This committee reviews training issues of relevance to the Hospital. The Educational Supervisor reports within the State Hospital to the Medical Director. Reports are submitted externally to the Training Programme Director for Forensic Psychiatry Higher Training in Scotland, and to local Training Programme Directors for Core Training.

3 ASSESSMENT

3.1 UNDERGRADUATE TRAINING

Teaching Programme for Edinburgh Undergraduate Medical Students

Day Visit and Clinical Attachments

The day visit and clinical attachments have been unable to occur this year due to Covid-19 restrictions on visitors to the site.

Teaching with Covid-19 Restrictions

To substitute for the afternoon lectures on forensic psychiatry which previously took place during the afternoon of the day visit, a one hour online live tutorial was organized. It takes place with forty students in four break out rooms with a TSH consultant psychiatrist allocated to each group. The teaching took place on six occasions during this academic year. The students have been somewhat reluctant to engage with numbers attending being low and many opting out of using their camera making small group teaching difficult. This has been the experience of online teaching across the board and is not limited to TSH teaching sessions. Teaching will continue on a virtual basis meantime and hopefully in-person teaching will be able to resume at some point in the future.

3.2 POST GRADUATE TRAINING

Core Training

Over the past year we have had six Core Trainees on placement at TSH, four from the West of Scotland and two from the East. To varying extents over that time these placements have been affected by the ongoing consequences of the Covid-19 pandemic, however this does not appear to have led to any significant detriment to the quality of their training. At points the management of physical health problems in our patient population has featured more heavily than it ought to as a consequence of reduced General Practitioner availability at TSH and because of additional pressures on NHS 24 resulting from the pandemic. It is notable that the GMC UK National Training Survey has recorded significant increases in levels of burnout across all medical specialties, including psychiatry, between 2019 and 2021. We have sought to support our trainees as much as possible at all stages of the pandemic and the implementation of largely single hub based working practices for trainee doctors working at TSH has been positively received and will continue, where possible, going forward. While there have understandably been challenges during the pandemic period there have also been training opportunities - for example trainee psychiatrists have been able to contribute to TSH Covid-19 Clinical Care Support documentation and their knowledge of physical healthcare gained from recent employment in general hospitals has been invaluable to the hospital during the past year.

First on call rota

Our first on call rota remained rather fragile over the past year, particularly during the period August 2020 to February 2021. We have a one in six overnight first on call rota which was populated by only four Doctors during the first part of the year. This meant that one third of overnights shifts had to be covered on a locum basis. The reason for this was that of our three Specialty Doctor posts only one was occupied at the time (one was vacant and another individual was on maternity leave). The situation improved somewhat in the period February 2021 to August 2021, however one of the six on call slots continued to be filled on a locum basis. Our Core Trainees and Specialty Doctors also work on a day time duty rota. Feedback received from Trainees indicated that operating the one in six rotas with only four doctors is too tight to give reasonable flexibility with regard to prospective cover.

Higher Specialty Trainees

Over the past year we have had three Specialty Trainees, two of whom were less than full time, working 50% and 60% respectively. This reflects a growing tendency in recent years for Trainee Doctors to prefer less than full time (LTFT) working, usually for either family or lifestyle reasons. We additionally had one Specialty Trainee who visited the hospital for special interest sessions with the Intellectual Disability Service for two months during September and October 2020. Our Specialty Trainees work under the supervision of Consultant Trainers, of which we have eight currently working at the State Hospital - see Appendix 1.

Specialty Trainees spend part of their weekly timetable undertaking research and special interest activities and overall generally spend less time at the State Hospital than Core Trainees and non-training grade Specialty Doctors. Their role is distinct, represents a progression from core training and maintaining appropriate distinction in their role from those of other non-Consultant Grade Doctors is important as they progress towards readiness for Consultanthood.

Senior Specialty Trainees in their final year of training can act up as a Consultant for a maximum period of 12 weeks. This has not occurred over the past year.

The State Hospital has performed strongly in recent years in terms of the quality of training for our Psychiatric Trainees. Last year trainee surveys were suspended due to the Covid-19 pandemic. It is understood that these went ahead during 2021 however at the time of reporting, the Scottish trainee survey results for Psychiatry were not available. The GMC UK National Trainee Survey for all medical specialties has however been published. A brief summary of the results of this survey are as follows:

GMC UK National Trainee Survey – What trainees and trainers told us

- Almost nine in ten trainees described their clinical supervision as good or very good. And three quarters said that virtual learning environments were being used effectively to support training.
- Eight out of ten trainees told us they felt confident they'd be able to progress to the next stage of training.
- Worryingly, half of secondary care trainers said they always or often felt worn out by the end of the day. The risk of burnout among trainees and trainers has reached the highest level since we introduced questions on this in 2018.
- Despite these pressures, 91% of trainers told us they enjoy their role. And 78% of secondary care trainers felt their working environment was fully supportive.

Teaching Programme

A series of six lectures is delivered by Consultant Psychiatrists to Trainee Doctors during the first three months of their placement at the State Hospital. The current programme encompasses six lecture topics which broadly cover the fundamentals of Forensic Psychiatry and related practice. A system allowing trainees to provide feedback on the quality of the lectures delivered has been developed. Over the past year six evaluation forms were returned. 28/30 (93%) of individual responses rated the lectures as 'excellent/strongly positive' while 2/30 (7%) responses rated the lectures as 'good/positive'.

Monthly Educational Programme

Due to the Covid-19 pandemic the weekly Journal Club was suspended in March 2020. Recently a monthly educational forum delivered using a "webinar" format has been introduced, organised by Dr Jana De Villiers. This gives Trainee Psychiatrists the opportunity to present cases, papers and audit/research, as well as to be educated by other internal and external speakers. This is important for their training and portfolio development and so far has been received positively.

New to Forensic Programme

A joint venture between NHS Education for Scotland (NES) and the School of Forensic Mental Health (SoFMH) the 'New to Forensic (N2F)' education programme is designed to meet the needs of clinical and non-clinical staff, both new and already working within forensic mental health services. The programme is designed to promote self-directed learning and is multi-disciplinary and multi-agency in approach. The mentee is supported throughout their period of study (recommended six months to one year depending on previous experience) by a mentor who is an experienced mental health worker. The programme has 15 chapters, each-of which (excluding chapter one) includes case scenarios of patients in various settings, from high secure to community psychiatric care.

Over the past year seven trainee psychiatrists have undertaken this programme, mentored by their Consultant clinical supervisors (in some cases doctors have already previously completed the programme elsewhere or on previous placements at TSH and/or are already very experienced in working within forensic settings). At the

point of commencement with TSH the medical secretary, who provides administrative support to the Educational Supervisor, liaises with staff at the Forensic Network to ensure new doctors are registered with N2F and provided with the materials to allow them to complete the programme under supervision during their post.

State Hospital Visits

Occasional requests for “taster visits” by Foundation Grade Doctors / Core Trainees / non-forensic Specialty Trainees are received on an intermittent basis. Generally speaking, these Doctors are curious to find out more about Forensic Psychiatry and in some cases they have an interest in pursuing Forensic Psychiatry as a career. Over the past year these visits have not been facilitated for reasons of infection control.

Psychotherapy Training

We have part-time input from a Consultant in Forensic Psychotherapy. This provides Balint / Reflective Practice sessions for non-Consultant Grade Doctors. Such work forms part of the core psychotherapy training requirements and feedback for same has remained positive.

Flexible/off-Site Working in common with other professional staff

Over the past year Trainee Psychiatrists have been provided with a mobile phone and laptop, and in most cases the laptop has been provided with a token to allow remote access to TSH systems, thus enabling them to undertake some of their duties off-site, as agreed with their supervising Consultant or when self-isolation is mandated. This approach is flexible, efficient and maximises productivity while reducing the risk of the introduction of viral & other transmissible infections to the TSH site.

Recruitment & Trends in Working Patterns

Reports via the Specialty Training Committees indicate improved levels of recruitment to training grade posts over the past year. Similar trends appear to be feeding through to recruitment to non-training grades (such as Specialty Doctors posts). TSH was previously unsuccessful in recruiting to our third Specialty Doctor post, however in July we offered the post to an individual who has accepted the post and will hopefully start work in August this year. This will assist in relieving some of the pressures of the past year with regard to trainee workload and gaps in our first on-call rota.

There are various schools of thought has to how the recent improved level of recruitment has arisen, however one likely reason is that travel restrictions have prevented doctors leaving the UK to work in other countries, commonly Australia and New Zealand for example. If this is the case then it would follow that in the future when travel restrictions are eased then it would be likely that we would again see gaps arising in training rotations and non-training grade posts, as has been the case in the years prior to the pandemic.

Furthermore, the Board are asked to note the growing tendency recently for Trainee Psychiatrists to work on a less than full time (LTFT) basis. If this trend continues and is aligned to vacancies arising from a return to overseas work placements, then the State Hospital could again become exposed to future recruitment difficulties and/or rota gaps.

Training Committee

This committee reviews medical training issues of relevance to the Hospital. It has continued in a modified form over the past year, chaired by the Educational Supervisor, taking account of the unique challenges of the period and the additional pressures experienced by trainee doctors arising from the pandemic. There has been greater utilization of small group meetings, either virtually or in-person when meetings restrictions allowed. It is expected this approach will continue for the time being.

GMC Recognition and Approval of Trainers (RoT)

Implementation of the GMC led recognition of secondary care trainers is now properly embedded and allows formal recognition of trainer status via the annual appraisal process of Doctors who have one or more of the following roles:

a) Named Clinical Supervisor in postgraduate training
b) Named Educational Supervisor in postgraduate training
c) Lead Co-Ordinators of undergraduate training at each local education provider
d) Doctors responsible for student's educational progress for each medical school

As shown in Appendix 1, the State Hospital remains in a strong position with regard to recognition of trainers, having capacity for providing training for doctors in Forensic Psychiatry, Intellectual Disabilities and Psychotherapy.

Representation at External Committees Relevant to Medical Education

The Educational Supervisor represents The State Hospital at the following:

- West of Scotland Specialty Training Committee (STC)
- National Forensic Psychiatry Specialty Training Committee (STC)
- NHS Education for Scotland Annual Review of Competence Progression (ARCPs)
- Taskforce for the Improvement of Medical Education (TIQME)

4 RECOMMENDATION

The Board is invited to note the following:

i) The continuing high standard of undergraduate and postgraduate medical training provided by the State Hospital, despite the challenges brought about by the Covid 19 pandemic.

ii) The hospital has a well trained and experienced Consultant workforce which is well positioned to continue to provide high quality training for medical students and post-graduate trainees in Forensic Psychiatry, Intellectual Disability and Psychotherapy.

iii) The pandemic has brought with it additional demands for Trainee Psychiatrists to provide physical healthcare for our patients which has been compounded by reduced General Practitioner availability within the hospital over the past year. Demands on Core Trainees were particularly high during the first six months of the year due to the absence of one third of our non-Consultant grade medical staff complement. This has shown an improving picture over the last six months and it is hoped that successful recruitment of a third Specialty (non-training grade) Doctor will add strength to our first tier medical cover and thus reduce the service demands on Psychiatric Trainees.

iv) Changes brought about initially by the pandemic, principally single hub working for Trainee Psychiatrists where possible, and the provision of technology to support more flexible/off-site working have been positively received and it is recommended that these should continue.

v) The reintroduction of a monthly educational programme has been positive and hopefully will continue to support the training and development of doctors on placement at the State Hospital, as well as other professional staff.

vi) The Board are asked to noted that non-Consultant grade medical recruitment has improved lately. This may be a temporary phenomenon related to the Covid-19 pandemic. Future easing of pandemic travel restrictions is likely to lead to a return to doctors travelling abroad to work and is likely to be aligned to the existing growing tendency for less than full time (LTFT) working amongst doctors. I would recommend that this is carefully monitored with regard to contingency plans for future non-Consultant grade medical staffing at TSH.

Consultant Forensic Psychiatrist & Educational Supervisor
3rd August 2021

Date of next annual report – August 2022

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	This is an annual report to the Board on issues relevant to medical education at The State Hospital
Workforce Implications	Nil
Financial Implications	Nil
Route to Board Which groups were involved in contributing to the paper and recommendations.	Prepared by individuals and informed by their involvement in various medical education committees
Risk Assessment (Outline any significant risks and associated mitigation)	N/A
Assessment of Impact on Stakeholder Experience	Nil
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)	There are no identified impacts.
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

	NES Clinical Supervisor Course or equivalent	NES Educational Supervisor Course or equivalent	Named Medical Trainer Role	Forensic, Intellectual Disabilities+ or Psychotherapy++ Higher Specialty Trainer	Self-declared Recognition of Trainers (RoT) section of appraisal (or do you intend to do so at next appraisal)?
Consultant Psychiatrist	Yes				Yes
Consultant Psychiatrist	Yes				Yes
Consultant Psychiatrist	Yes		Undergraduate Supervisor	Yes	Yes
Principle Medical Officer	Yes			No	Yes
Consultant Psychiatrist	CEP** Level 2			Yes+	Yes
Consultant Psychiatrist	CEP** Level 2		Undergraduate Supervisor		Yes
Consultant Psychiatrist	Yes	Yes		Yes	Yes
Educational Supervisor	Yes	Yes	Postgraduate Supervisor	Yes	Yes
Consultant Psychiatrist	CEP** Level 2			Yes++	Yes
Consultant Psychiatrist	CEP** Level 3		Psychotherapy Tutor (Lothian)	Yes++	Yes
Consultant Psychiatrist	Yes			Yes	Yes
Medical Director	Fellow HEA***	Yes		Yes	Yes

*Employed by Scottish Government **CEP = Clinical Educator Program ***HEA = Higher Educational Academy

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	28 October 2021
Agenda Reference:	Item No: 11
Sponsoring Director:	Medical Director
Author(s):	PA to Medical & Associate Medical Directors
Title of Report:	Medical Appraisal and Revalidation Annual Report 2020/21
Purpose of Report:	For Noting

1 SITUATION

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

2 BACKGROUND

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

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

3 ASSESSMENT

- The Revalidation and Appraisal Committee met once in 2020-21: 3 May 2021. The next meeting will take place on 1 November 2021.

- Revalidation Policy
  The Revalidation and Appraisal Policy was approved by the Senior Management Team on 3 August 2016 and is available on the Intranet. The Policy was reviewed in August 2019.

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

- Revalidation System
  Revalidation system has been used for 12 Consultants and 2 speciality doctors in 2020-21. This includes one doctor on secondment to Scottish Government. One Consultant is appraised and revalidated through the Chief Medical Officer system.

  Revalidation system for former / retired colleagues with honorary contracts was in place (n=1). This colleague has now retired fully and therefore no further appraisals will be conducted.

- Appraisals
  From 1 April 2020 to 31 March 2021, of the 14 medical staff within The State Hospital revalidation system, 11 were appraised during this period. Two appraisals occurred outwith the reporting period and one doctor retired.

- Revalidation
  All revalidations are up to date.

- Multi-source feedback
  Multi-source feedback using the SOAR system is now being submitted by medical staff at appraisal meetings. This is required once per 5 year cycle.

- CARE Questionnaire
  The CARE questionnaire was issued to patients in November 2020 for all Consultants, one Specialty Doctor and one Consultant Psychotherapist in July 2021.

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

- Case based discussions are included in the appraisal process. In response to Covid 19, meetings including the Case Based Discussion meeting were suspended. Following feedback from the medical staff group, these meetings have not restarted at this time. Discussion in relation to recommencing Case Based Discussion will form a part of the medical staff remobilisation plan.

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Consultants	Last Date for Recommending Revalidation	Date of Revalidation	CARE Questionnaire Return	Form 4 Completed	Appraisal 01/04/19-31/03/20	Appraisal 01/04/20-31/03/21	Appraisal 01/04/21-31/03/22	AMP Training	
								Forensic	Core & Capacity
	20/11/2023	31/10/2018	Dec 2020	Yes	28/08/2020	20/07/2021		01/02/19	29/05/21
	15/10/2026	16/10/2021	Dec 2020	Yes	24/09/2019	01/10/2020	26/10/2021	01/02/19	
	01/09/2026	02/09/2021	Dec 2020	Yes	04/02/2020	31/08/2020	01/06/2021	01/02/19	29/05/21
	12/02/2025	04/04/20	Dec 2020	Yes	29/11/2018	28/01/2020	01/06/2021	25/11/19	21/06/18
	19/12/2024	15/11/2019		Yes	3/10/2019	21/01/2021	16/10/2021	01/02/19	29/05/21
	01/08/2026	31/05/2021	Dec 2020	Yes	15/03/2019	30/03/2021		01/02/19	31/10/19
	27/12/2022	27/12/2017	Dec 2020	Yes	05/11/2019	27/11/2020	04/10/2021	20/09/21	29/05/21
	28/03/2024	11/03/2019	Dec 2020	Yes	28/02/2019	02/02/2021		01/02/19	29/05/21
	20/12/2026	24/05/2021	Dec 2020	Yes	12/12/2019	23/11/2020	25/10/2021	01/02/19	29/05/21
	28/07/2026	31/05/2021	July 2021	Yes	20/01/2020	16/02/21	25/10/2021		29/05/21
	20/03/2025	11/12/2019	Dec 2020	Yes		05/10/2020	12/11/2021	24/01/18	09/12/19
Specialty Doctors									
	29/06/2024	05/06/2019	July 2021	Yes	17/07/2020	24/08/2021		01/02/19	29/05/21
	03/02/2022						05/10/2021 19/10/2021	6-8/7/21	
	03/08/2024							16-18/2/21	
Appraised by Other Organisations									
	15/12/2023	15/12/2018	Dec 2020	Yes	30/04/2019	15/10/2020	12/10/2021		29/05/21

4 RECOMMENDATION

The Board is invited to note the content of the Medical Director's Report.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	N/A
Workforce Implications	Revalidation and appraisal are requirements to work as a doctor and essential to ensuring our continued medical workforce.
Financial Implications	Nil
Route To Board Which groups were involved in contributing to the paper and recommendations.	HIS requirement. Report will be shared with MAC.
Risk Assessment (Outline any significant risks and associated mitigation)	No significant risks identified
Assessment of Impact on Stakeholder Experience	Captures feedback on stakeholder experience and provides opportunity to improve this
Equality Impact Assessment	EQIA Screened – no identified implications
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	N/A
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One X There are no privacy implications. ☐ There are privacy implications, but full DPIA not needed ☐ There are privacy implications , full DPIA included.

Paper No. 21/77

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	20 October 2021
Agenda Reference:	Item No: 12
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 August 2021. The report highlights activities in relation to QA and QI and outlines how these relate to strategic planning and organisational learning and development. It contributes to the strategic intention of The State Hospital to embed quality assurance and improvement as part of how care and services are planned and delivered

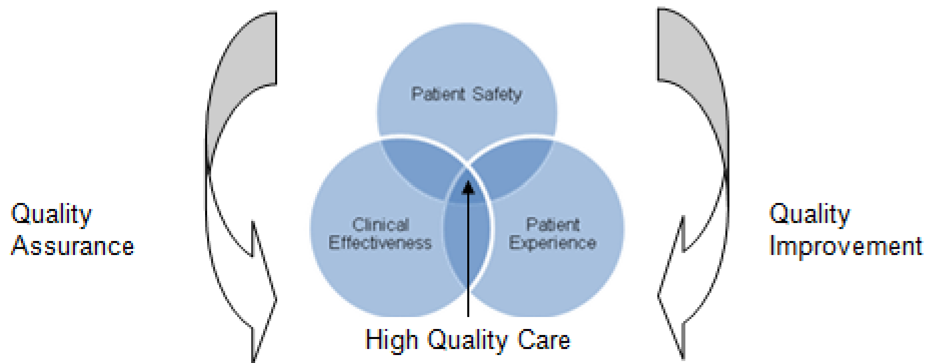
2 BACKGROUND

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

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

- Building improvement knowledge, skills and capacity.

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



3 ASSESSMENT

The paper outlines key areas of activity in relation to:

- Quality Assurance through:
    - Clinical audits and variance analysis tools
    - Clinical and Support Services Operating Procedure Indicators Report
- Quality Improvement through the work of the QI Forum
- Capacity Building for Quality Improvement
- Realistic Medicine
- Evidence for quality including analysis of the national and local guidance and standards recently released and pertinent to The State Hospital

4 RECOMMENDATION

The Board are asked to note the content of this paper

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	The Quality Improvement and Assurance report supports the Quality Strategy and Corporate Objectives by outlining the actions taken across the hospital to support QI and QA

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

QUALITY ASSURANCE AND IMPROVEMENT IN THE STATE HOSPITAL

OCTOBER 2021

ASSURANCE OF QUALITY

Clinical Audit

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

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

- Audit to ensure the process is followed when PRN medication is administered
- Physical health equipment audit against the Care Quality Commission recommendations for equipment that should be available on Psychiatric wards for physical healthcare
- Blood Borne Virus (BBV) Audit
- Record Keeping Audit (incorporating nurse progress notes for every shift, scanned documents and unvalidated entries)
- Post Physical Intervention Audit

A national benchmarking report from the Prescribing Observatory for Mental Health (POMH) for the Use of Clozapine. The data collection for this took place earlier this year.

Findings and actions from these included:

Audit to ensure the process is followed when PRN medication is administered
Areas showing improvement
- All oral and IM does of the same medication were written separately on the prescription sheet.
- Although a large proportion of patients in TSH are routinely written up for PRN medication, they are not routinely administered 'prn' medication.

Areas requiring further improvements
- There were 57 occasions out of 206 (27.7%) where no reason was put on the administration kardex as to why the medication had been given.
- On the 4 occasions where patients were administered IM medication, there was no evidence of oral treatment being offered prior to administration. On 2 occasions on Ward A these were noted on the PRN Psychotropic Form on RiO where the response and observation monitoring section was completed but no NEWS form was attached to the RiO form or filed in the clinical documentation section of RiO. On the 2 occasions on Ward B where IM PRN was administered there was no evidence that oral medication was offered in the first instance and on both occasions the PRN Psychotropic Medication form was not completed on RiO but the incidents where noted in the progress notes on RIO.

This improvement plan will be taken forward through the Medicines Committee

Physical health equipment audit against the Care Quality Commission recommendations for equipment that should be available on Psychiatric wards for physical healthcare
Recommendations from this audit included:

- Physical Health Steering Group discuss the areas for improvement and put forward a business case for the purchase of items they think should be included either on each ward, or one per hub.
- Based on this audit we should aim to locate areas that need to re-equip instruments and equipment to those wards (as per the findings above and standards suggested by Care Quality Commission).

- Identify drawers for specific purposes and if required this should be locked with access key for medicine nurse and doctor.
- Identify things that can be removed from each of the Treatment rooms to make space for methodically storing equipment that can be retrieved easily.
- Label all the drawers and cabinets to clearly identify contents in it. Notice to be pasted on the drawers to strictly adhere to what needs to be stored in the specific drawers so additional equipment are not placed in them because space is not available elsewhere.
- BM meters should have easy access to batteries.
- De-cluttering of the Treatment room is required with management of space and consideration given to placing an examination couch in each of the wards.
- All equipment to be stored in cabinets or drawers and not in available spaces on the cabinets or surfaces as this limits space and is potentially an infection risk.
- The concept of treatment room for only physical examination and pharmacological purposes needs to be re-asserted as we risk this room becoming a proxy store room.

These recommendations will form an improvement plan and taken forward through the Physical Health Steering Group.

Blood Borne Virus (BBV) Audit

Areas showing improvement:

- There was an 11.6 % increase to 96.9% in the BBV admission assessment being completed on RiO.
- The number of annual BBV assessments completed on RiO increased from 90.5% in 19/20 to 93.9% in 2021
- The number of patients with BBV bloods tested increased from 69% to 93.9%.

Areas requiring further improvements:

- On the 31 occasions where the BBV Admission Assessment was completed 17 (54.8%) were completed on the day of admission, this is a decrease of 10.7%.
- BBV admission assessments completed more than 2 days after admission increased from 5 to 9. On 2 occasions the assessment was not recorded on RiO until more than 70 days after admission.

The improvement plan will be monitored through the Infection Control Committee.

Post Physical Intervention Audit

Areas showing improvement:

- For all 18 (100%) occasions where secure holds were recorded, there were Post Physical Intervention Assessment (PPIA) forms completed by Senior Clinical Cover on RiO. This is the first time this has been achieved within this audit.
- Of the 18 completed PPIA forms 17 (94%) had been closed off in RiO
- For the 18 occasions on Datix where physical interventions took place there were 9 (50%) occasions where injuries were recorded, all (100%) of which had a corresponding PPIA form completed.

Areas for improvement:

- Of the 18 PPIA forms completed, the incident time on the PPIA form matched with the incident time recorded in Datix on 11 (61%) occasions.
- For the 9 occasions where injuries were recorded in Datix and the corresponding PPIA form, the information matched on 4 (44%) occasions.
- For the 9 instances where injuries were recorded, entries in the progress notes, Datix and the PPIA forms cross matched on 2 (22%) of occasions.
- Of the 18 occasions where a patient had been taken to the floor and observations should have been recorded within the NEWS, there was 1 (6%) completed NEWS available within RiO.
- There were 15 (83%) occasions following physical intervention where a PRN was administered, 10 (67%) of these were recorded on Medication Forms within RiO.

The improvement plan will be monitored through the Patient Safety Group.

Audits currently underway, or due to commence include Record Keeping, T2/T3, Diabetes Audit and Antipsychotic Therapy Monitoring Audit.

Clinical Governance Committee
At the meeting on 12th August 2021 the following papers were presented with a number of quality assurance and improvement activities contained within them:

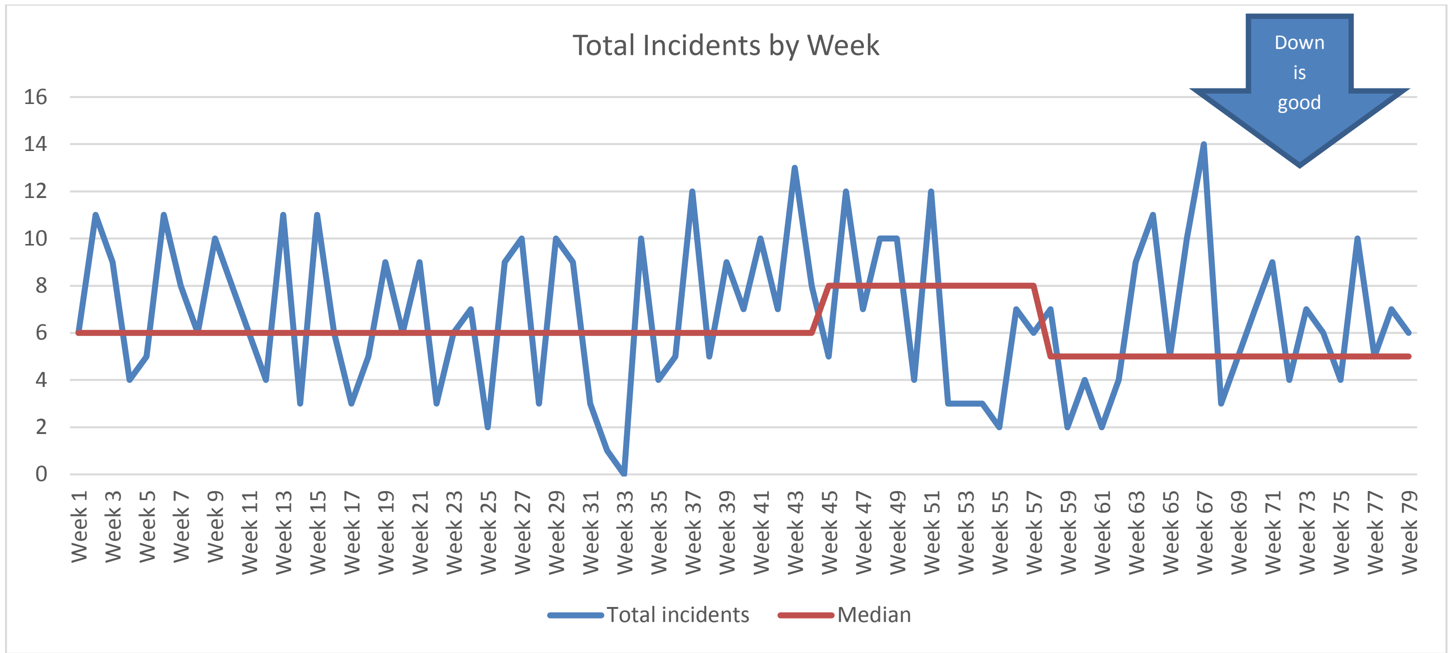
- Covid 19 Update
- Risk Register 12 Monthly Report
- Patient Safety 12 Monthly Report
- Forensic Medium and High Secure Care Standards Action Plan
- Staffing and Care Report
- Clinical Model Report
- 3 x Category 1 Review Reports
- Learning from Feedback Quarterly Report
- Learning from Complaints Quarterly Report
- Incident and Patient Restrictions Quarterly Report

Areas of Good Practice were noted and will be contained within the Clinical Governance Committee Annual Report.

Daily and Weekly Indicator Reports

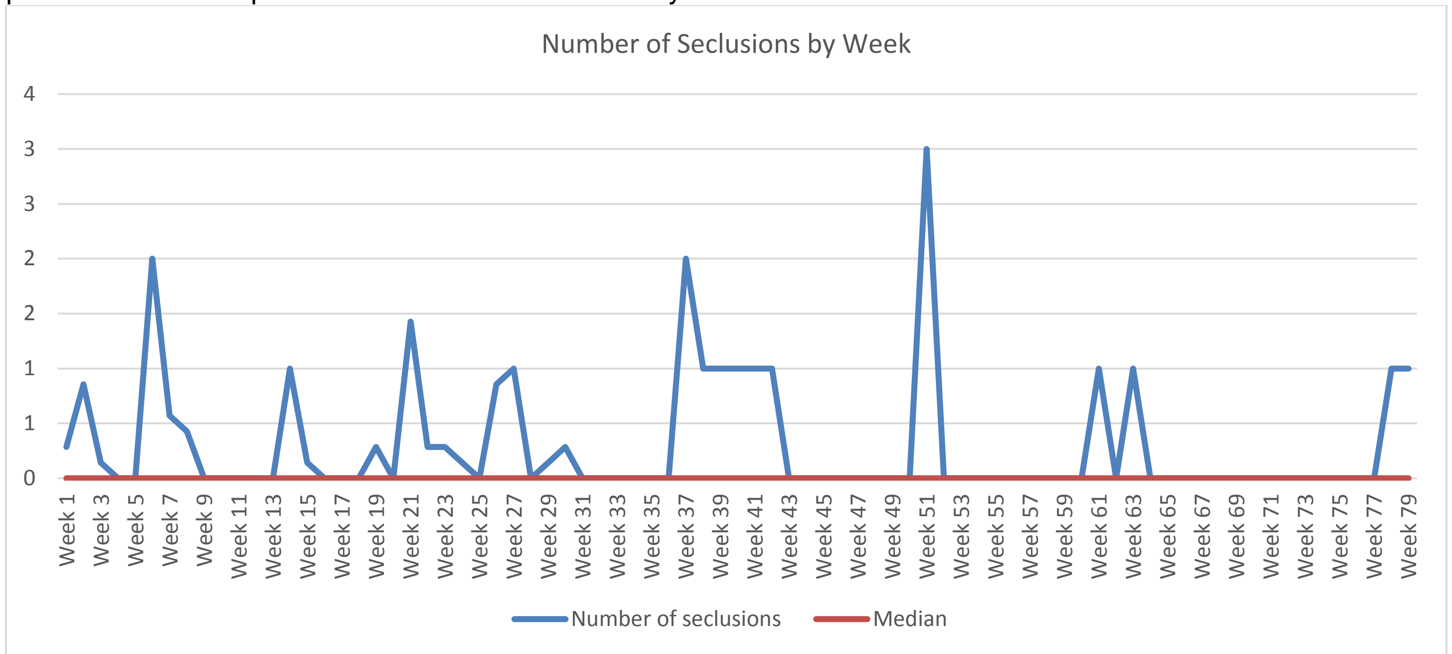
Clinical Quality continue to collate and present the data that gives the Corporate Management Team the assurance that it is safe to continue with the Interim Operational Policy. A sample of the most recent data is below. The full report can be provided on request:

Datix assaults, attempted assaults and behaviour
As can be seen in the graph below, we have seen one positive shift and one negative shift in the data since data collection commenced. A negative shift was seen between week 39 and 44 (22nd December and 1st February) with the median moving from 6 to 8, and then a positive shift between week 51 and 57 (26th March and 6th May) with the median moving from 8 to 5. Since then we have seen random variation. There was a peak at week 67 with 14 incidents: 1 attempted assault; 11 behaviour and 2 self-harm.



Seclusions

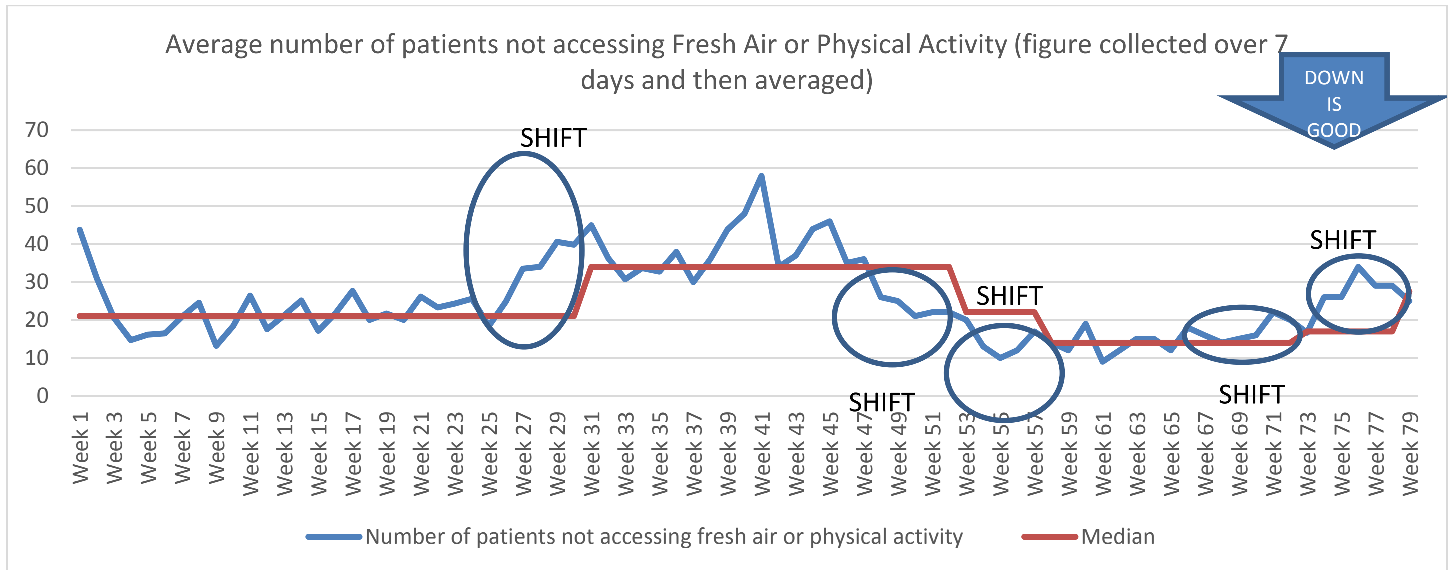
As can be seen the seclusion data continues with random variation. We saw a period of no seclusions between week 64 and week 77. Week 78 we saw one patient being secluded due to their ongoing presentation. The patient was in seclusion for 7 days.



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.

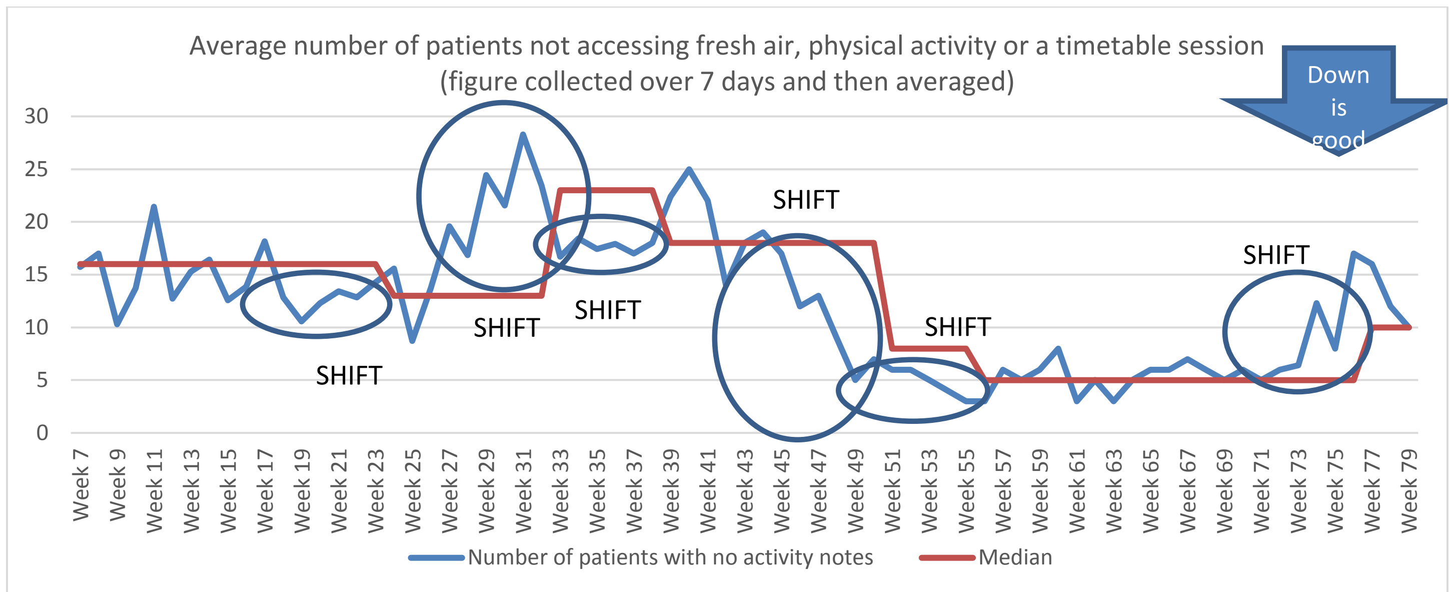
As can be seen we have seen 2 positive shifts in the data between week 48 and 53 (26th February and 8th April) and week 53 and 58 (8th April and 13th May). The first positive shift moved the median from 34 to 22 and the second moved it from 22 to 14. we have seen 3 negative shifts in the data between week 26 and 31 (22nd

September and 2nd November), week 66 and 72 (2nd July and 13th August) and week 73 and 79 (28th August and 7th October). The median has moved to 28. The negative shifts correlate with ward staff shortages in July and the weather deteriorating at the other 2 shifts.

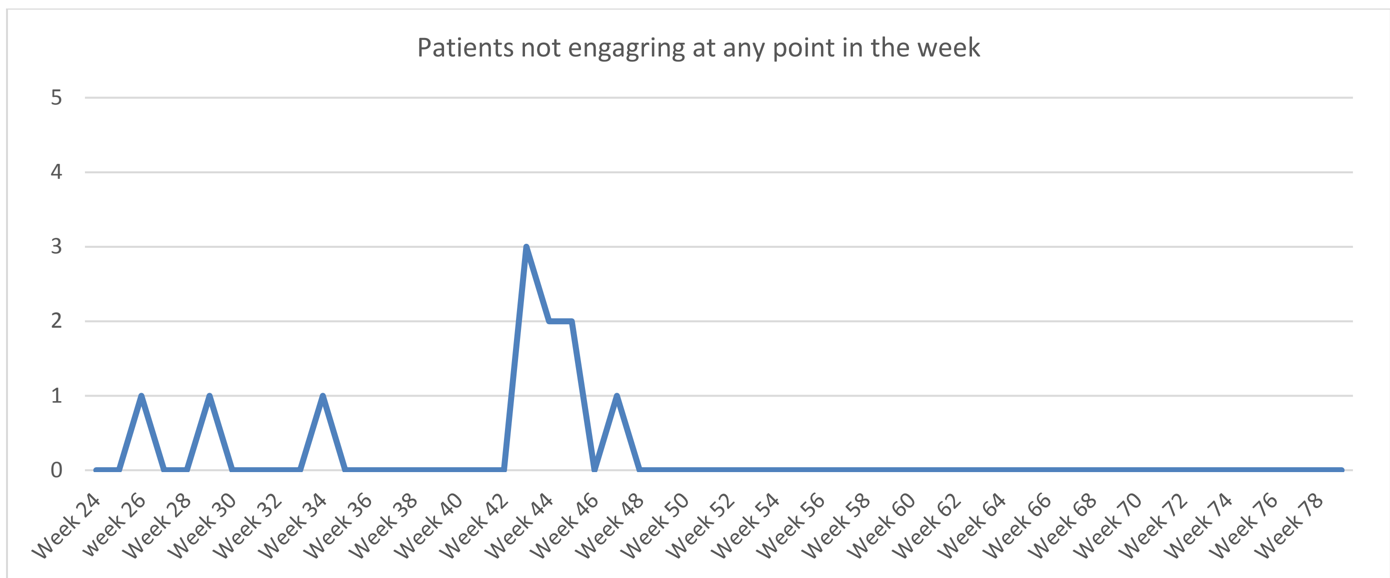


Patients not engaging with fresh air, physical activity or timetable sessions (this is an average daily figure)

One of the main purposes of collecting the daily indicator data was to ensure that there were limited patients that were not engaging with some form of activity i.e. fresh air, physical activity or a timetable session on a daily basis. From week 7, 12th May we started to monitor this. As can be seen, since then we have had 4 positive shifts and 2 negative shifts. The first positive shift came between weeks 17 and 23 (21st July and 7th September); the second between weeks 32 and 38 (3rd November and 21st December) and the third between weeks 43 and 50 (19th January and 18th March) and the fourth between week 51 and 56 (18th March and 29th April). The 2 negative shifts came between weeks 26 and 32 (22nd September and 9th November 2020) and week 72 and 76 (13th August and 10th September 2021). The most recent shift came at a time when we required 12-16 additional staff, both day shift and back shift, for patients on level 3 observations due to their presentation at that time and we were having to close wards due to staff shortages.



Patient not engaging with fresh air, physical activity or a timetable session at any point in the week
When we look to see how many patients have had either fresh air, physical activity or a timetable session at any point in the week the data shows all patients have engaged with some form of activity at some point in the week since week 48 (26th February – 4th March).



QUALITY IMPROVEMENT

QI Forum

The QI Forum meets regularly to champion, support and lead the quality improvement initiatives across the hospital and raise awareness and understanding of QI approaches. The QI Forum continues to support and embed QI approaches to innovation and learning using the model for improvement as a guiding approach. At its meeting on 6th October 2021, the QI Forum agreed to hold a development session to refresh and build momentum and provide focus and clarity for the future direction of the QI Forum over the next 12 – 18 months.

Quality Improvement Capacity Building

Developing capacity and capability for individuals and teams across TSH has been a focus of activity for the QI Forum. National training is available through NHS Education for Scotland (NES), specifically the Scottish Improvement Leaders Programme (ScIL) and Scottish Coaching and Leading for Improvement (SCLIP) training which are particularly useful within TSH. The QI Forum has engage with these national programmes and support TSH applicants as they progress through the development opportunities. TSH currently has 3 colleagues participating in ScIL and 2 commencing SCLIP training in October 2021. In addition, a QI Forum member has been invited to be part of faculty development with the NES Quality Improvement Team. Specifically, they will be part of the faculty of the Scottish Coaching and Leading for Improvement Programme (SCLIP) Cohort 26, which is likely to commence in Autumn 2021.

Pre-Admission Specific Needs Information Form Quality Improvement Project – Summary

The Pre-Admission Specific Needs Information Form was introduced to ensure that any specific requirements regarding subjects such has hearing, mobility, health, nutrition and hydration, spiritual and pastoral care, communication and smoking will be addressed prior to admission to ensure the provision of high quality patient care. The RMO completes the form whilst assessing the patient for admission to TSH. Once this information is entered into RiO, automatic emails will be generated to Heads of Service.
Following implementation of the form, in 2020 an audit was carried out to offer the organisation assurance that the Pre-Admission Specific Needs Assessment form was being completed for all patients admitted to The State Hospital (TSH). The audit ran from 1 January to 31 December 2019. During the audit period there were 33 admissions to TSH and the Pre-Admission Specific Needs Assessment form was only completed on 12 (36%) occasions. The Mental Health Practice Steering Group (MHPSG) have responsibility for the efficacy of the Pre-Admission Specific Needs Assessment form and due to the poor audit results suggested a Quality Improvement project to address the issue.

The MHPSG had also received feedback from patients and carers, via PPG and Carers Group, that getting a patient telephone PIN approved after admission took forever. Discussion at the group led to the suggestion of adding a contacts section to the existing Pre-Admission Specific Needs Assessment form to speed up this process.

The project started on 1 February 2021– it's aims were to:

- Improve the completion of the Pre-Admission Specific Needs Assessment Form to 80% by June 21
- To have patient contact details prior to admission to ensure that the patient has a hospital telephone PIN when they arrive at the State Hospital

The first stage of the project was to put a formal process and tools in place to ensure completion of the assessment. In order to create this process, discussions were held with the Person Centered Improvement Lead, RMO's and Medical Secretaries, Health Records and Estates.

After an number of PDSA cycles the percentage of forms completed increased to 82% (18 out of 22). This was a significant improvement (46%) and exceeded the 80% target set at the start of the project. The 4 occasions where the form was not completed were fed back to the 3 relevant RMO's.

Looking at baseline data on phone activation in the 2 months prior to the project starting (Dec 20 and Jan 21) the average time between admission and the patient's phone line being activated was 25 days– ranging between 2 and 78 days with a median of 8. After the QI project (Feb-Jul 21) the average time between admission and the patient's phone line being activated was 4 days after admission - ranging from 4 days prior to admission to 35

days after admission – with a median of 0. This is an excellent improvement. Initially it was thought that improvement to this could be achieved by adding a contacts section to the form but was, in fact, achieved by introducing the practice of Health Records notifying Estates of the date of all new admissions

Realistic Medicine

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

The six key themes of RM are:

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

The RM and SPSP Project Manager role was successfully recruited in August 2021 and since their appointment they have connected and liaised with the other Programme / Project Managers in their respective territorial boards to share learning and offer support where needed; this will be a monthly meeting going forward. In addition to this, they have approached individuals and committees linked to the projects detailed in the action plan to introduce themselves and to touch base, offering any support as and when required.

The Scottish Government require an interim update where we detail our progress to date against our action plan. The reporting template issued by Scottish Government has been completed by the Project Manager and RM Lead which is cited in Appendix 1. This will be submitted by close of play on 29 October 2021.

Utilising the principles of RM and aligning these to patient safety, TSH launched their first Learning into Practice (LiP) meeting on 13 September 2021 which was met with great enthusiasm. This is an internal process to support clinical teams to think about and share learning from their clinical practice and identify areas for improvement. It is based upon systems thinking and improvement methodologies and supports the local delivery of recommended national approaches to patient safety and staff learning. The LiP system includes a monthly meeting open to all staff, with the emphasis of ensuring clinical staff have the opportunity to attend. The Flash Report from the meeting held in September is contained within Appendix 2.

EVIDENCE FOR QUALITY

National and local evidence based guidelines and standards

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

Over a 12-month period, an average of 200 evidenced based guidance documents issued from a variety of recognised bodies can be reviewed for relevancy by the Clinical Quality Facilitator. During the period 1 August to 30 September 2021, 31 guidance documents have been reviewed. Six were recorded for information and awareness purposes and 2 required completion of an Evaluation Matrix – these were for a NICE guideline

relating to CKD and a King's Fund document entitled Courage of Compassion. The remaining 23 documents were considered not relevant to The State Hospital or were overridden by Scottish guidance.

TABLE 2 EVIDENCE REVIEWS

Body	Total No of documents reviewed	Documents for information	Evaluation Matrix required
Mental Welfare Commission (MWC)	2	2	0
Scottish Public Services Ombudsman (SPSO)	4	4	0
Healthcare Improvement Scotland (HIS)	1	0	0
National Institute for Health & Care Excellence (NICE)	23	0	1
The King's Fund	1	0	1

As at the date of this report, there are currently 5 evaluation matrices awaiting review by their allocated Steering Group. The progress of the first 2 evaluations from HIS and the MWC was temporarily paused due to The State Hospital adapting to the COVID-19 pandemic however as per Gold Command, action on matrix completion began again at the start of July 2020. The responsibility to review these matrices changed ownership from the PMVA Review Group to the Patient Safety Group which recommenced meetings in September 2020. Work is ongoing with both. The Osteoporosis guidelines required input from the GP which has proven difficult to access. This guideline is currently under review by the new Practice Nurse. The review of the Public Health England guideline was unable to be completed within the tight deadline set by the Supporting Healthy Choices group due to poor attendance at the 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. The remaining MWC guidance entitled Rights, Risks and Limits to Freedom has had an evaluation matrix completed and is awaiting review and final sign off at the next group meeting in October 2021.

TABLE 3 GAP ANALYSIS SUMMARY

Body	Title	Allocated Steering Group	Current Situation	Publication Date
HIS	From Observation to Intervention: A proactive, responsive and personalised care and treatment framework for acutely unwell people in mental health care	MHPSG (via Patient Safety)	Evaluation matrix completed with 28 outstanding recommendations Patient Safety meeting took place mid-September. Evaluation matrix to be revisited upon creation of updated draft Clinical Engagement Policy.	January 2019
MWC	The use of seclusion	MHPSG (via Patient Safety)	Work ongoing. Release of updated Seclusion Policy currently on hold due to ongoing work with Clinical Engagement Policy currently being drafted with seclusion tier 1 and 2 being incorporated. Both to be launched together.	October 2019
SIGN	UPDATED: Management of Osteoporosis and the prevention of fragility fractures	PHSG	Currently under review by Practice Nurse	June 2020

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
MWC	Rights, risks and limits to freedom	Patient Safety	Gap analysis completed with 92% compliance achieved. Document will be taken back to October Patient Safety meeting for final sign off with outstanding recommendations to be added to Action Plan.	March 2021

Paper No. 21/77

Appendix 1: Realistic Medicine Interim Report

REALISTIC MEDICINE INTERIM UPDATE 2021/22: THE STATE HOSPITAL

Report Date:	31/10/2021
Owner:	RM Team, TSH
RAG Status:	

What we have done well

- We now have our RM Project Manager in post.
- We have further developed our RM intranet resources and promoted RM across TSH with an RM update seminar for all staff held in May and promotion of the latest CMO annual report in staff bulletins.
- We have promoted the work of TSH and the RM approach via a range of national media articles and YouTube clips on the TSH YouTube channel published in June.
- We have continued to build our QI infrastructure by supporting staff through national programs and local QI mentoring
- We have progressed many of the projects on our RM work plan
- We have designed, set-up and started our Learning into Practice (LiP) system to review clinical scenarios and apply all principles of Realistic Medicine into the learning points, actions and recommendations.

What we would like to share

- There is nothing at this stage we need specific support to share.

Key Risks against our action plan

- COVID-19 pandemic: potential for rapid change to TSH situation which may affect services and work streams.
- Staff capacity and engagement at operational level.

What we learned

- Complex problems require complex solutions
- It's been challenging to progress the RM work across the forensic network nationally, in the context of the pandemic.
- People want to contribute but can struggle to find the capacity, time, energy.
- Sometimes small changes can make big differences

What our next steps are

- Review and update our RM Action Plan for 2021/22
- Work through our RM communication plan to deliver information sessions to clinical teams
- Try to progress RM work with the wider forensic network

Areas for further support

- Would be good to hear if/how other Boards have rolled out and monitored completion of the SDM module
- Any ideas and guidance around useful ways to share RM progress out with TSH e.g. website, other for a, including approaches to updating Board website

Alignment with national tools & support

- We have promoted completion of the Turas SDM module with all medical staff at TSH. Our Learning and Development team are exploring with NES how we can monitor completion rates of the module.
- There are not currently any Atlas of Variation maps relevant to our area of work.
- We are not using the BRAN questions in TSH yet. We need to think about how they fit with our work and the existing mechanisms in place to support decisions around treatment

Appendix 2: Flash Report of LiP Meeting

Learning into Practice (LiP) Meeting – Flash Report

NHS SCOTLAND

Meeting Date:	13 September 2021
Title of Meeting:	SRK use and DVT
Hosts:	Mull Clinical Team
LiP Format:	Complex Case Review
Chair:	Jon Patrick

Contributors:

- Lindsay Tulloch
- Janette Stevenson
- Briju Prasad
- Aileen Burnett
- Gordon Skilling

Attendees: 37 Total

- Advocacy
- Clinical Quality
- Corporate Planning
- Forensic Network
- Nursing
- Nursing Practice Development
- Occupational Therapists
- Pharmacy
- PMVA Team
- Psychiatry
- Psychology
- Risk and Resilience
- Social Work
- Training and Development

What we would like to share – One key message

This was the first LiP meeting and it was great to have such good turn out from a diverse range of teams and departments. Thank you so much for your support.

The Mull clinical team hosted a Complex Case Review which illustrated the sometimes extreme clinical challenges that our staff, patients and carers encounter, the requirement for clinical staff to make frequent, complex, dynamic assessments and decisions as part of their every day work and that even when our work is carried out as intended, complications can occur.

Reflecting and learning form these in order to improve our systems where possible is essential to our ongoing journey of improvement.

Summary of Issues Discussed:

Summary of background/events leading to admission
Formulation
Timeline of first 2 weeks of admission
Nursing care
Pharmacological issues
Venous thromboembolism (VTE) risk assessment
Summary of systems factors
Actions/recommendations

Learning and Actions:

- Learning
  - Even when everything goes to plan (and we do everything the policies say), unintended harms can and will happen – this is no one's fault
  - Before this event, VTE assessment was not within formalised training or policies.
  - The complexity of our work requires that staff constantly make adjustments and decisions based upon what they are faced with in the moment. This is the reason most things go well.
  - Gaps in our systems can be covered up by staff "going over and above" (medical and pharmacy services in different Boards)
  - Remember we can go out with TSH for expert advice/support
  - We need to leave more time for discussion at the LiP meeting!
- Actions
  - Ensure VTE monitoring and assessment built into relevant training and policies & procedures
  - Review and understand pros and cons of pharmacy services coming from different Board to medical support
  - Capture patient experience and feedback on being at the centre of challenging situations and what could be improved from their perspective.
  - Ensure staff have clarity on definitions of seclusion.
  - Promote use of Clinical Pause (including for pre-admission planning in complex cases)
  - Convene LiP Panel (as per LiP Guidance) to review and improve LiP meeting

Summary of System Factors (PAcE Model)

People
Patient: Aggressive
Treatment resistive
Hated being in SRK's
Complex medical picture
Staff: Skilled in managing violence / aggression
High levels of compassion
Trained in SRK use
Dedication to providing care

Activity
Prolonged period in SRK's (immobility)
Mental state risks
Complex fluid situation
Balancing sedation
Early stages of pandemic
Mull 2 MSR temporarily unavailable
Built flash points into care by sleeping in MSR initially
Uncertainty about what was and wasn't seclusion

Environment
High stress environment for patient and staff
Communication was key
Good support from directors and PMVA lead
Great MDT involvement
Good use of Clinical Pause
Mindful of Advance Statement
Challenges of medical and pharmacy services in different Boards

THE STATE HOSPITALS BOARD FOR SCOTLAND

CLINICAL FORUM CF(M) 21/04

Approved Minutes of the Clinical Forum held at 10.00am on Tuesday 27 July 2021 via Microsoft Teams

Present:

Sandie Dickson	*Person Centred Improvement Lead*
Dr Jana De Villiers	*Consultant Psychiatrist*
Dr Kerry Jo Smith	*Clinical Psychologist*
Carolin Walker	*Professional Nurse Advisor **(Vice Chair)***

Apologies:

Dr Aileen Burnett	*Consultant Clinical Psychologist*
Dr Sheila Howitt	*Consultant Forensic Psychiatrist*
Marcus Topping	*Practice Nurse*
Julie Warren	*Corporate Services*
Fiona Warrington	*Clinical Pharmacist*

In Attendance:

Fraser Breed	*Dietician*
David Hamilton	*Social Work Team Leader*
Jim Irvine	*Clinical Liaison Security Manager (part)*
David McCafferty	*PA to Chair/CEO, Corporate Services **(minute)***
Brian Moore	*Chairman*
Sheila Smith	*Clinical Effectiveness Team Leader*

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

The Forum Vice Chair, Carolin Walker, welcomed everyone to the meeting and in particular Brian Moore who was in attendance at his first Clinical Forum meeting. Apologies were noted as detailed above.

NOTED.

2 CONFLICT(S) OF INTEREST

There were no conflicts of interest declared.

NOTED.

3 APPROVAL OF PREVIOUS MINUTES

The minutes of the previous meeting held on 25 May 2021 were approved as an accurate record aside from ‘In Attendance’ list on the first page – whereby Sandie Dickson should be noted as a member.

APPROVED.

4 URGENT MATTERS ARISING

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

NOTED.

5 REVIEW OF ROLLING ACTIONS LIST

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

NOTED.

6 DATA PERFORMANCE WORKBOOK – FOR REVIEW

It was agreed that this item would be deferred to next Clinical Forum in September to allow for Dr Sheila Howitt to be in attendance.

NOTED

7 ANNUAL REVIEW 2021

Nil to update at this meeting.

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

(a) Nursing and Allied Health Professions Advisory Committee

Members were advised that this meeting was cancelled and will convene again in September.

NOTED.

(b) Medical Advisory Committee

Members **received** and **noted** the approved Minutes of the Medical Advisory Committee held on 10 May 2021.

Dr de Villiers advised members that there were no issues to address at this meeting.

NOTED.

(c) Psychology Professional Practice Meeting

Members were made aware that the Psychology Professional Practice Meeting had yet to be reinstated. Fortnightly department meetings continued to convene. MBTI currently running with four patients in attendance which was being facilitated in the Skye Centre. Making Healthy Changes group currently has six patients in attendance. Low intensity group planned for August which would facilitate new admissions. It was noted that staffing groups from the across the hospital would be involved.

NOTED.

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

Members received and noted the written update from Skye Centre Manager dated 19 July 2021. Sheila Smith provided an update on the current situation around annual health reviews and that these were not happening in full. Definition of annual health reviews is being explored and it had been established that face to face reviews were not relevant. KPI being produced to look at timeline the month before reviews stopped to allow better insight into this situation. Health reviews were now being reinstated and it was hoped that results of this investigation would provide a better service going forwards.

NOTED.

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

It was agreed that an update would be provided at the next meeting in September.

NOTED.

10 CHAIR UPDATE

Brian Moore, Chairman provided members with an introduction and confirmed he took up the Chairman post on 5th July 2021 and David McConnell would continue as Vice Chair providing experience and continuity. Three recent non-executive appointments included Pam Radage, Stuart Currie and Cathy Fallon who took up post in February and April time. The Chairman noted his term would be over the course of two years and went on to discuss the Barron Report and the focus on the recommendations provided within it. The clinical model, new ways of working, digital approaches and how the organisation had come through Covid was noted as well as staff engagement and the priorities for the Board such as physical health and wellbeing, healthy choices and BMI support programme. The Chairman went on to explain that a Special Board meeting convened last week to sign off on the annual accounts. The Chairman noted the current challenges around on-site working and that he and the new non-executives looked forward to having the opportunity to being able to work on-site more frequently as soon as the current situation allows.

NOTED.

11 UPDATE ON MAPPING OF CLINICAL MODEL

Members were briefed on an exercise carried out by Dr Sheila Howitt and Monica Merson with Dr Howitt providing regular updates to the group on developments. In the absence of both, and with further discussion yet to take place, it was agreed that this would be brought to the next meeting for further updates.

NOTED.

12 MWC GOOD PRACTICE GUIDE – FOR NOTING

Members **received** and **noted** Power of Attorney Quick Guide. There was agreement that it would be helpful to explore the benefits of power of attorney and where it comes into the pathway of patient care. It was noted that once a power of attorney was in place it was difficult to challenge it and that there was a requirement for capacity at the time / patient required to be mentally well with long term implications to be explained. There was further agreement that it would be helpful to include POA to the CPA journey. Sheila Smith agreed to progress this at the next Mental Health Practice Steering Group and provide a feedback to the next Clinical Forum in September.

ACTION: SHIELA SMITH

NOTED

13 MWC PUBLICATION SCHEME – CORPORATE REPORTS – FOR NOTING

Members **received** and **noted** Publication Scheme 2021. Question raised if this would be shared more widely across the hospital and confirmation was given that this had been included in Monday's Staff Bulletin. There was agreement that this should be shared in a Special Bulletin and Sheila Smith agreed to contact Head of Communications to arrange for this.

ACTION: SHIELA SMITH

NOTED

14 ANY OTHER COMPETENT BUSINESS

Fraser Breed noted the intention from a dietetic perspective that a discussion had taken place with psychology and positive change was hoped to carry out a comprehensive dietetic assessment on

patients around weight history and eating behaviours. Frances Waddell was noted to be the lead for this going forwards. Fraser Breed advised the group that he would be leaving his current role and that a replacement representative to future Clinical Forums was being explored.

NOTED.

15 DATE AND TIME OF NEXT MEETING

The next meeting of the Clinical Forum would take place at 10am on Tuesday 28 September 2021 via Microsoft Teams.

Meeting concluded at 1210 hours

Paper No. 21/ 78

NHS SCOTLAND

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	28 October 2021
Agenda Reference:	Item No: 14
Sponsoring Director:	Director of Workforce
Author(s):	Head of Human Resources / HR Advisor
Title of Report:	Attendance Performance Summary
Purpose of Report:	For Noting

1 SITUATION

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

2 BACKGROUND

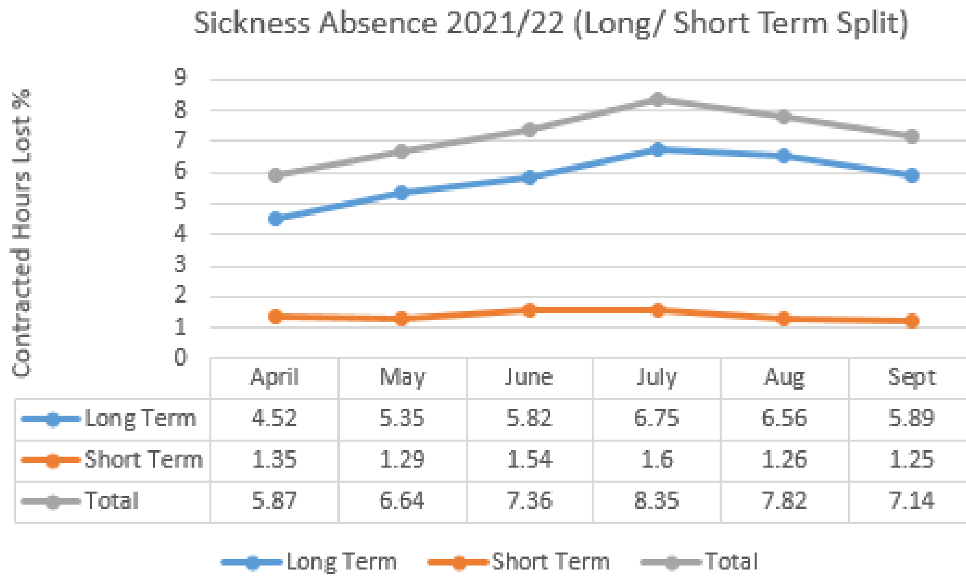
The State Hospital is required to achieve a sickness absence rate no higher than 5%. The data used is extracted from, SWISS (the national repository) and SSTS (the Board time recording system).

3 ASSESSMENT

The sickness absence figure from 1 April 2021 to 30 September 2021 is 7.20% with the long/short term split being 5.81% and 1.38% respectively. This data is produced through SSTS based on direct input at board level, and is dependent on accurate and timely input by line managers.

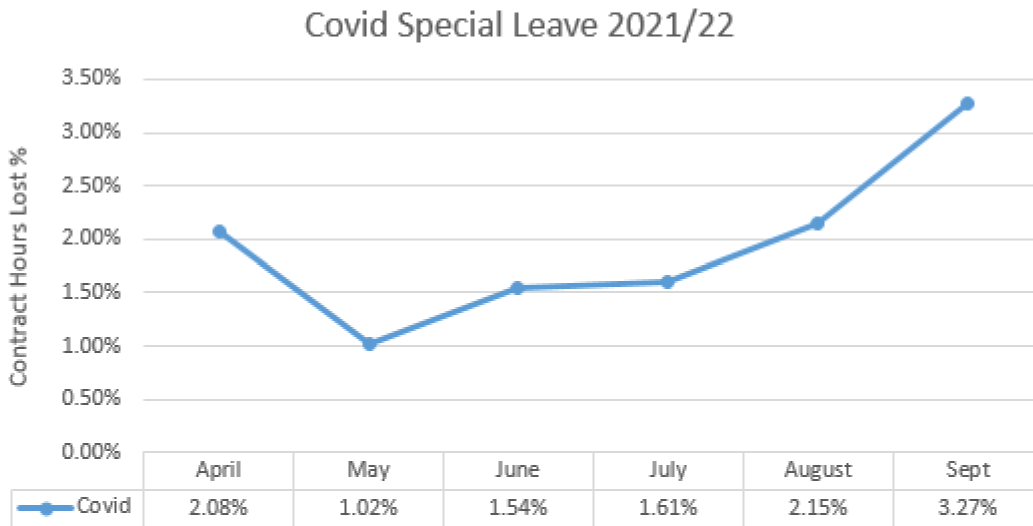
This data is broken down further into monthly detail in the tables that follow.

Table 1 - 2021/22 Sickness Absence (SSTS)



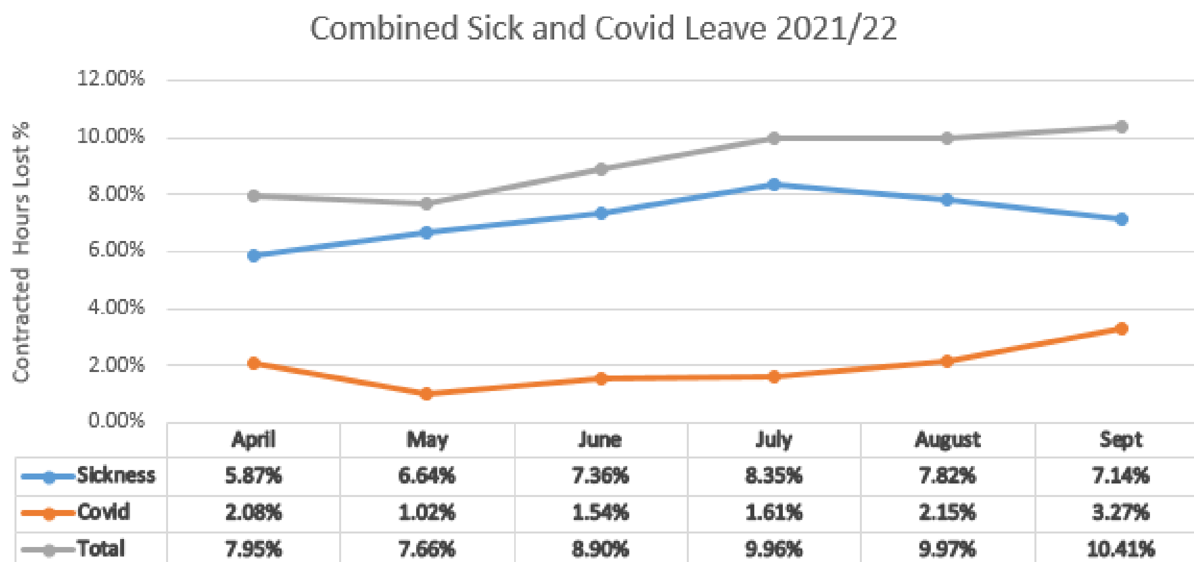
	April	May	June	July	Aug	Sept
Long Term	4.52	5.35	5.82	6.75	6.56	5.89
Short Term	1.35	1.29	1.54	1.6	1.26	1.25
Total	5.87	6.64	7.36	8.35	7.82	7.14

Table 2 – 2021/22 Covid Special Leave (SSTS)



	April	May	June	July	August	Sept
Covid	2.08%	1.02%	1.54%	1.61%	2.15%	3.27%

Table 3 - 2021/22 Covid Special Leave/ Sickness Combined (SSTS)



	April	May	June	July	August	Sept
Sickness	5.87%	6.64%	7.36%	8.35%	7.82%	7.14%
Covid	2.08%	1.02%	1.54%	1.61%	2.15%	3.27%
Total	7.95%	7.66%	8.90%	9.96%	9.97%	10.41%

Table 4 - National Comparison Data (SWISS)
1 September 2020 to 31 August 2021 – Swiss Reporting for September unavailable

	Absence Rate		
	Total	Long Term [1]	Short Term [2]
Scotland	**5.04**	**3.52**	**1.52**
NHS Ayrshire & Arran	4.66	3.37	1.29
NHS Borders	4.79	3.25	1.54
NHS National Services Scotland [4]	3.40	2.34	1.06
NHS 24	7.45	4.91	2.54
NHS Education For Scotland	1.45	1.06	0.39
Healthcare Improvement Scotland	2.36	1.53	0.83
NHS Health Scotland [4,5]	-	-	-
Public Health Scotland [4,6]	2.23	1.32	0.91
Scottish Ambulance Service	6.61	4.89	1.72
The State Hospital	5.81	4.62	1.19
National Waiting Times Centre	4.82	3.16	1.66
NHS Fife	5.12	3.68	1.44
NHS Greater Glasgow & Clyde	5.55	4.04	1.51
NHS Highland	4.84	3.33	1.51
NHS Lanarkshire	5.81	4.35	1.47
NHS Grampian	3.93	2.37	1.56
NHS Orkney	4.61	3.15	1.46
NHS Lothian	4.61	2.93	1.68
NHS Tayside	5.13	3.53	1.61
NHS Forth Valley	5.98	4.44	1.54
NHS Western Isles	5.50	3.90	1.59
NHS Dumfries & Galloway	5.24	3.60	1.64
NHS Shetland	3.02	1.73	1.29

The data above is received from SWISS, and is on a rolling for the period between 1 September 2020, and 31 August 2021 as these are the most up to date figures available at time of reporting.

4 RECOMMENDATION

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

MONITORING FORM

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

THE STATE HOSPITAL BOARD FOR SCOTLAND

Date of Return / Meeting:	28 October 2021
Agenda Reference:	Item No: 15
Sponsoring Director:	Finance and eHealth Director
Author(s):	Deputy Director of Finance
Title of Report:	Financial Position as at 30 September 2021
Purpose of Report:	For Noting

1 SITUATION

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

2 BACKGROUND

Scottish Government are ordinarily provided with an annual Operational Plan and 3-year financial forecast template. The Operational Plan has for 2021/22, as in 2020/21, been paused and replaced with the Board remobilisation plan.

At SG's request, TSH formally sought six months' funding for Covid-related costs, based on half of last year's funding provision. We have now received Q1 monies and Q2 is due. The SG position for Covid-related funding re Q3 and Q4 is expected to be confirmed imminently.

There are potential delays in the Perimeter Project which are being monitored by the Project Board and for which any delay costs will be quantified for consideration where there has been a Covid related impact.

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

3 ASSESSMENT

3.1 Revenue Resource Limit Outturn

The annual budget of £39.848m is primarily the forecast Scottish Government Revenue Resource Limit allocation, and anticipated additional recurring allocations.

The Board is reporting an under spend of £0.133m to 30 September 2021. PAIAW funding has been released to September – this is a significant hit to the Board because of our high levels of overtime and high Nursing vacancies.

AFC pay arrears were paid in August, with no funding pressure arising – however there is a further circular issued affecting posts at B8 and B9 therefore a pressure of around £0.035k is likely but, following Q2 financial reviews, reserves as yet underutilised are expected to offset this.

3.2 Key financial pressures / potential benefits.

Revenue (RRL): -
Office 365
An accrual was set aside March 2021 to help address the licence cost pressure, which is being monitored with the Head of eHealth, and for which the various licence options are currently under evaluation with regard to cost scoping.

Covid-19
50% of 20/21 funding has been requested for the first six months of this financial year, being closely monitored in year, and in liaison with SG. We did however receive Q1 only in the June Allocation. We are currently confirming with SG as to utilising some of this for the costs regarding student nurses taken on last year. There is now strong likelihood that Covid cost pressures will extend after Q2, with potential roll forward of some of the Q1 and Q2 funding, and further application to be made thereafter once the SG plan is notified and agreed for Q3 and Q4.

Clinical Model
The review of the clinical model identified potential recurring savings in ward nursing – with values to be confirmed – which would have been beneficial from early 2020/21. Planning work in this respect has now recommenced.

Patient Visiting
There is expected to be a Business Case put forward to CMT for additional staff cost pressures needed to cover patients' visitor's services (due to changes re Covid).

Travel
Benefits have arisen due to most meetings and courses now being virtual through the Covid crisis.

Erostering
This is expected to be a pressure, unless met from RRL, which is yet to be confirmed from SG once the national approach and overall national financial position is agreed – for which the project is underway. At this early stage, potential pressure of circa £250k are possible for TSH in 2022/23.

Capital (CRL): -
Additional funding has been requested and approved, over and above the recurring £0.269m, specifically for MSR and Key Safe priority works, amounting to an estimated £0.500m.

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

Further tables/details are noted below on Nursing and Security.

Directorates	Annual Budget £'k	Year to Date Budget £'k	Year to date Actuals £'k	(budget less actuals) for period 6	Budget WTE	Actual WTE
Nursing And Ahp's	22,399	11,318	11,444	(125)	401.63	418.98
Security And Facilities	6,546	3,317	3,229	88	120.64	115.75
Medical	2,939	1,470	1,385	85	21.70	21.24
Chief Exec	1,936	978	919	58	22.07	20.00
Human Resources Directorate	938	471	453	18	14.05	14.44
Finance	2,761	1,393	1,413	(21)	29.02	31.42
Cap Charges	2,857	1,429	1,311	118	0.00	
Misc Income	(600)	(379)	(446)	67	0.00	0.00
Central Reserves	71	(493)	(337)	(156)	(1.00)	0.00
	39,848	**19,503**	**19,370**	**133**	**608.11**	**621.83**

Medical – The underspend will be reduced with realignment of Clinical Effectiveness costs.

CE – Social Work SLA savings are now revised, also pending senior post recruitment.

HR – Learning Centre currently underspent in Corporate training, principally due to Covid.

Finance – ehealth overspend in non-pay – currently under investigation.

Capital Charges –The budget is carried forward from previous year meantime, awaiting SG confirmation of the required change to the allocation for the forecasted 2021/22 position (core to non-core adjustment). This may be vired and address some capital pressures.

Misc. Income – The budget now recognises income for exceptional circumstance patients, within which individual boards are being tracked. A vat benefit for last year for capital now transferred to capital (from revenue) in September.

Central reserves
Savings unidentified were initially phased as twelfths, however given the release of PAIAW for April to September in the September ledger gave rise to moving reserves from period 12 so this benefit has been offset with bringing forward the unidentified savings from October to March in to September. Other significant reserves are for Covid Q1, Apprenticeship Levy and AME, and any additional RRL not yet released (delay in projects).

Nursing & AHPs

Nursing And Ahp's	Annual Budget £'k	Year to Date Budget £'k	Year to date Actuals £'k	YTD Variance (budget less actuals) for period 6	Budget WTE	Actual WTE
Advocacy	148	74	74	(0)	0.00	
AHPs & Dietetics & SLAs	716	358	256	102	13.33	11.42
Hub & Cluster Admin & Clinical Operations	864	433	362	71	24.97	19.08
NPD & Infection Control & Clin Gov	453	231	206	25	5.80	5.57
Psychology	1,388	694	710	(16)	19.50	20.19
PA's pending NOC's	25	25	152	(127)	0.00	6.53
PCI & Pastoral	228	114	109	5	3.40	3.69
Skye Centre	1,798	901	859	42	37.33	34.78
Ward Nursing	16,779	8,488	8,714	(226)	297.30	317.72
	22,399	**11,318**	**11,444**	**(125)**	**401.63**	**418.98**

Highlights from Nursing & AHP's: -

Ward nursing overtime equates to actual WTEs worked. Covid funding now released mid-year (end September 21) for Q1 and Q2. PAIAW now released for Q1 and Q2.

Others – Vacancy benefits for many of the other departments.

PA's - There has been structural realignment to some budgets, for which adjustments are awaiting finalisation.

Security & Facilities

Security And Facilities	Annual Budget £'k	Year to Date Budget £'k	Year to date Actuals £'k	YTD Variance (budget less actuals) for period 6	Budget WTE	Actual WTE
Risk & Resilience	126	63	51	12	2.00	2.00
Facilities	4,632	2,344	2,233	111	78.87	74.41
Security	1,788	910	947	(37)	39.77	39.34
Perimeter Security	0	0	(1)	1	0.00	0.00
	6,546	**3,317**	**3,229**	**88**	**120.64**	**115.75**

Highlights from Security and Facilities: -

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

Facilities – Housekeeping vacancies and holiday pay not fully utilised. Kitchen vacancies. Electricity underspend but this is expected to reverse with increase in prices imminent

Security – some of the overtime and on-call pressures will be met from Covid monies Q1 and Q2 spend now budget matched Other overtime is for high sickness levels and is being monitored.

4 ASSESSMENT – SAVINGS

The following table summarises the savings set by Directorate.

Cumulative Savings	Savings - Annual Target	Achieved to date / post base adj'ts	(Still to be achieved) / over achieved
Directorate	**£'k**	**£'k**	**£'k**
Chief Executive	(143)	98	(45)
Finance	(26)	11	(15)
Nursing & AHP's	(392)	192	(200)
Human Resources	(15)	3	(12)
Medical	(20)	16	(4)
Security & Facilities	(215)	151	(64)
Unidentified (phased 1/12ths ytd)	(438)	(106)	(544)
Total	**(1,249)**	**365**	**(885)**

While an improved level of the proportion of recurring savings is a national / audit focus, it should be noted that of the Hospital's budget nearly 85% of costs are pay/staff-related. The remaining non-pay cost element from which recurring savings are being pressured is therefore only 15%.

By comparison, many territorial boards have a non-pay cost element of around 65%; other National boards have non-pay costs ranging from around 80% (NSS, NES) to 30/40%.; and certain boards treat vacancy savings, or a proportion thereof, as recurring savings.

National Boards Contribution

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

There continues to be pressure on the collective boards due to the £15m challenge not yet being fully identified. The recurring level which the Board agreed for 2019/20 and 2020/21 remains at £0.220m, and this is also forecast for 2021/22.

5 CAPITAL RESOURCE LIMIT

The recurring capital allocation anticipated from Scottish Government for the year is £0.269m. We are awaiting further allocation, and £0.052 released to CRL from RRL September for an earlier VAT correction.
Over and above this is additional funding requested (as noted in paragraph 3.2), and the perimeter fence project allocation, for which this shows Year 2 of 2.

CAPITAL CRL 2021/2022 AS AT SEPTEMBER 2021	ANNUAL PLAN	YTD PLAN	YTD SPEND	under/ (over)
	£'k	£'k	£'k	£'k
PERIMETER SECURITY				
STANLEY SECURITY SOLUTIONS LTD		1,111	1,111	0
DOIG & SMITH		1	1	0
THOMSON GRAY LTD		99	99	0
TSH STAFFING APR - MAR'22		96	96	0
SENSTAR CORP		20	20	0
VAT RECLAIM		-55	-55	0
PERIMETER SECURITY TOTAL (Yr 1 of 2)	**2,879**	**1,273**	**1,273**	**0**
CAPITAL				
IM&T		0	0	0
OTHER		59	59	0
CAPITAL	**269**	**59**	**59**	**0**
Total CRL	**3,148**	**1,332**	**1,332**	**0**

6 RECOMMENDATION

Revenue
Year to date position is £0.133m underspend, with breakeven anticipated for the year-end.

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

The Board 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 Board Which groups were involved in contributing to the paper and recommendations.	Board requested
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:	28 October 2021
Agenda Reference:	Item No: 16
Sponsoring Director:	Director of Security, Estates and Facilities
Author(s):	Programme Director / Head of Estates and Facilities
Title of Report:	Perimeter Security and Enhanced Internal Security Systems Project
Purpose of Report:	For Noting

1. SITUATION

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

2. BACKGROUND

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

The Project Oversight Board meets monthly. The POB last met on 21st October 2021 and is scheduled to meet again on 18th November 2021.

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

3. ASSESSMENT

a) General Project Update:

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

b) On-site works Completed:

The Board has been updated on the range of works completed on site from June 2020 to date and these include**:**

Item	Completion
Installation and testing of Fibre Network across site	June 2020
Tubestile replacement	July 2020
Installation of CCTV in Skye Centre	July 2020
Installation of CCTV in Arran Hub	October 2020
Installation of CCTV in Mull Hub	December 2020
Installation of CCTV in Family Centre	December 2020
Installation of CCTV in Tribunal Annex	December 2020
Installation of CCTV in Lewis Hub	March 2021
Installation of CCTV in Lewis Hub	June 2021
Factory Acceptance Test	June 2021
Installation of Car Park CCTV	August 2021

c) Works underway:

Further works are planned including:

Item	Due date
Radio System Installation	November 2021
Grounds and Patient Walkways CCTV	October 2021
Control Room equipment installation	January 2022

d) Offsite works:
Production and review of:

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

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

e) Project Timescales & Quality Issues:
As previously reported, the project's planned completion date moved from mid October 2021 to December 2021 due to the impact of COVID, delays on approval of Design Packages and Risk and Method Statements. A mid programme strategic review took place and Stanley recast the programme to reflect the outcomes of that meeting, with a revised completion date of 21st February 2022 and a revised Contract end date of 13th April 2022. Following revision of the completion date to 2nd March 2021 a further revised programme has been proposed and is currently under review. This projects completion in late April 2022, with a contract extension to May 2022. The programme includes outdoor working across the winter and is therefore vulnerable to further delay.

The alterations to programme include 57 additional days accrued due to COVID delays (30 days), the inclusion of the Running Track CCTV (5 days) and the changes to the Perimeter CCTV and Grounds and Patient Walkways CCTV design (22 days).

All quality targets are being met.

f) Finance – Project cost

The project is proceeding according to the current projected cost plan, though estimates, quotes, commitments and other adjustments such as VAT reclaim, COVID recharges and other minor changes may potentially result in a small overspend.

The key project outline is:

Project Start Date:	April 2020
Planned Completion Date:	March 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):	£10,491,727
Total costs to date (Inc. VAT) at 16th October 2021:	£ 8,783,491

The expenditure to date is in line with the plan agreed with the contractor, with the schedule planned for the months to come confirmed on a rolling basis in order to ensure that the Hospital's cash flow forecast is aligned and that our SG funding drawdown is scheduled accordingly. All project payments are processed only once certification is received confirming completion of works to date.

While it is not a prerequisite of the project, regular reports to the SG Capital team are also being provided to notify of progress against total budget.

Actual spend to date at 17th October 2021 is in line with Stanley planned schedule of works

Breakdown of actual spend to date –

Stanley	£ 6.415m (Certified Value, 5% retention not applied)
Thomson Gray	£ 0.636m
Doig & Smith	£ 0.008m
VAT	£ 1.411m
Staff Costs	£ 0.313m
	£ 8.783m

4 RECOMMENDATION

That the Board **note** the current status of the Project

MONITORING FORM

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

Paper No. 21/ 81

NHS SCOTLAND

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	28 October 2021
Agenda Reference:	Item No: 17
Sponsoring Director:	Director of Finance, eHealth and Audit
Author(s):	Head of eHealth
Title of Report:	Digital Transformation - Update
Purpose of Report:	For Noting

1 SITUATION

The eHealth department support the requirements of the Board and the ongoing digital transformation agenda. This update provides an overview of activities in the last three months since the last annual report to Board.

2 BACKGROUND

Digital transformation continues to demand a focus on the key projects identified in the Hospital – monitored through the eHealth Group and the Digital Inclusion Group, through which existing and new initiatives are raised, prioritised and monitored to bring benefits to both patients and staff. This update details key recent activity for the Board's information.

3 ASSESSMENT

3.1 Office 365 Licencing

The national licencing agreement for Office 365 has been recently renewed. Changes in licencing types available under the new agreement could have a significant financial impact to the Board if the licence types in use are not changed. Our current licence type (E5) is no longer available and the equivalent replacement licence is significantly more expensive. To reduce our financial exposure work has been undertaken to compare the new licence types with our E5 licence and, if possible, recommend a change of licencing to the new lower cost licence type. All licence types available under the new national O365 agreement now have the necessary security applied as part of the licence. Previously this was only provided with the E5 licence and moving to the lower cost licencing has no increased threat to the Board. If staff feel they need to retain the capabilities of the E5 licence they will be asked to submit a request to the eHealth department. If the proposed licence swap is implemented it will provide a projected saving of over £180K per year.

3.2 IT Hardware

Equipment supply issues are still having an impact on service although we have recently received some new laptops. Laptop and desktop computers ordered under the national agreement are still taking five months for delivery from the date the order was placed. There is a slight reduction in timescales for computer monitors but we have no indication when docking stations for laptops will be available. This might delay the replacement of older laptops in use but an alternative docking station is being sourced for cost and availability.

3.3 RiO EPR Upgrade

The upgrade to our Electronic Patient Record RiO is underway after a significant delay due to Covid-19. Work to create the new hardware environment has been completed and testing by the Information team is underway. Once initial testing of the new system is complete access to the new system will be provide to staff involved in the second stage of testing. This project is expected be completed by April 2022 and will need the involvement of all departments using RiO at present.

3.4 IT Helpdesk SLA

As the IT Infrastructure/Helpdesk team has expanded it is felt an agreed service level agreement (SLA) can now be supported and is in the early days of development. This SLA will set timescales in relation to IT Helpdesk calls and the expected completion date. Once the SLA is finalised it will set the agreed timescales for all calls logged via the IT Helpdesk and will provide all staff with a timescale for the completion of their IT calls and request.

3.5 Helpdesk Calls

Below is an overview of all calls to the IT Helpdesk from 1 July to 30 September 2021. The highest number of calls was for general IT advice with RiO / EPR administration in second place. There has been an increase in the percentage of calls closed within target date. In the charts below, it should be noted that the measurement of calls received and closed will not tally, to take into account calls closed which had been received prior to 1 July but then closed during this snapshot period.

Further work is needed to refine the SLAs for call types, and a new Tableau Dashboard is also under construction to facilitate this. This will help to refine the measurement of performance, especially around the average time for resolution. This currently include calls which are for example more complex or require to be placed on hold dependent of solutions being found through external providers.

Start Da.. 01/07/2021

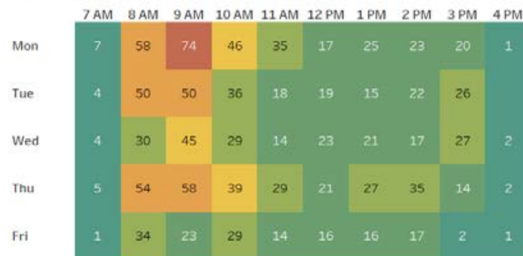
End Date 30/09/2021

IT HELPDESK CALLS

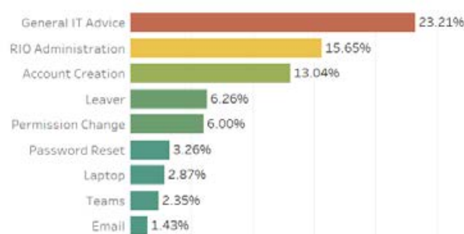
Logged Calls	Closed Calls	Open Calls	Calls On Hold	Avg Resolution (Days)	Within Target Date
1,195	1,246	106	30	14.80	1,067 (86.68%)

Calls Logged(Bar) and Closed(Line)

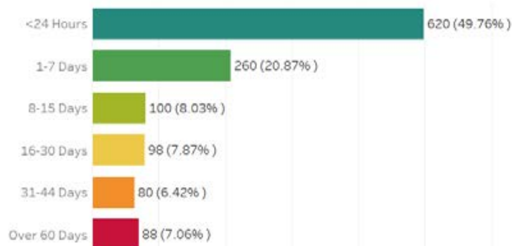
Time Logged



Call Categories



Time To Close



3.6 Cyber security update

There have been four high level cyber alert notifications and one informational alert from the NSS Cyber Security Operations Centre (CSOC) Team in the last six months. The high level alerts related to vulnerabilities within local and national systems. Recommendations and guidance from Microsoft and CSOC were followed, where applicable.

There have been three separate notifications from CSOC regarding local users having interacted with malicious/phishing emails/websites. Again these have been dealt with locally with either the deletion of the emails, users performing password resets or devices being wiped and rebuilt if needed. Datix notifications are being recorded for this type of incident.

Locally we have had six notifications of virus/malware detection from our internal system. Action has been taken to resolve these including removal of quarantined files or the wiping and rebuilding of devices.

As digital inclusion increases we will continue to ensure our cyber defences are actively managed and maintained – also focusing on the need to ensure our staff are sufficiently educated on how to stay safe online.

4 RECOMMENDATION

The Board is asked to note the update.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Supporting Board Digital Transformation Strategy
Workforce Implications	Resource demands noted within specific eHealth projects .
Financial Implications	Revenue and capital costs noted within specific eHealth projects
Route To Board Which groups were involved in contributing to the paper and recommendations.	Requested by Board as part of remobilisation/ workplan
Risk Assessment (Outline any significant risks and associated mitigation)	Noted within specific eHealth projects
Assessment of Impact on Stakeholder Experience	Noted within specific eHealth projects
Equality Impact Assessment	Noted within specific eHealth projects
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 (within individual eHealth projects) □ There are privacy implications , full DPIA included.

Paper No. 21/82

THE STATE HOSPITALS BOARD FOR SCOTLAND

NHS SCOTLAND

Date of Meeting:	28 October 2021
Agenda Reference:	Item No: 18
Sponsoring Director:	Director of Security, Resilience and Estates
Author(s):	Risk Management Facilitator
Title of Report:	Risk & Resilience Annual Report 2020/21
Purpose of Report:	For Noting

1 SITUATION

This annual report provides the Board with details of the activity undertaken within the Risk and Resilience department over period 1 April 2020 until 31 March 2021.

2 BACKGROUND.

The Risk and Resilience Department (Formerly Risk Management) is now part of the Security, Facilities and Estates Directorate (Previously under the Finance and Performance Directorate) and is involved in a range of functions from the maintenance of risk registers, development and review of Resilience Plans, Incident Reporting and Enhanced Reviews, Health & Safety, Duty of Candour to the administration

The Audit Committee receives reporting and has oversight for evaluating the system of internal control and corporate governance, including the risk management strategy and related policies and procedures. This report was reviewed and discussed by the Audit Committee in detail at its meeting on 7 October, and it was agreed that the report should be submitted to the Board at its next meeting.

3 ASSESSMENT

Changes within Department

During 2020/21 various changes were made within the department following a review by senior management:

Change of Name and Directorate

Following an internal review of Directors portfolios, the Risk Management Department was moved from the Finance and Performance Directorate to the Security, Estates and Facilities Directorate. The

department was renamed the Risk and Resilience Team to reflect new roles and the focus of the department.

Change in Management Structure

In December 2020 the Risk Management Team Leader left post. Recruitment began in March 2021 for a new post – Head of Risk and Resilience with an aim to have the position filled by the end of May 2021. The post will report directly to the Director of Security, Estates and Facilities and work alongside the Head of Security and Head of Estates. The Risk Management Facilitator has been working in a promoted post since December 2020 – Interim Risk Management Team Leader until recruitment for head of department is concluded.

Complaints and Claims

The State Hospital complaints and claims function has been managed by the Board Secretary under Corporate Services since December 2020. The Complaints and Claims Officer also moved from Risk Management to continue their role, due to the removal of this role and service within the department the team member was not replaced. The Risk and Resilience Team continues to provide Datix administrative support to the Complaints as part of their function as Datix Administrators. The Board will receive dedicated reporting on the management of complaints separately.

Merger of Committees

The Health and Safety Committee, Resilience Committee and Risk Management Group are in the process of merging into one larger oversight group. Actions for this group will be taken over by the Hospital Management Team/Organisational Management Team or relevant sub Group. The Group is due to meet initially in April with bi-monthly meetings thereafter.

Areas of Good Practice

In addition to the positive outcomes highlighted throughout the report, there are a number of additional areas of good practice in relation to risk management across the hospital including:

- Effective monitoring of risk information by groups and committees
- Regular monitoring of patient-specific risks by clinical teams
- Strong evidence on learning from incidents, with local action being taken to minimise recurrences

Areas of good practice within the risk management department include:

- Continued development of the Corporate Risk Register with risk owners
- Updated Local Risk Register work completed and continued development in place
- Completion of implementation of RSM recommendations
- Support to Covid-19 Support Team throughout pandemic.
- Risk Management Facilitator has completed Root Cause Analysis Training to ensure at least one member of the team is fully trained as per policy.
- Risk Management Facilitator has been able to take on role of Interim Risk Management Team Leader whilst recruitment takes place.
- Improved delivery of Cat 1 and 2 reports, ensuring they are completed on time.

4.2 Identified issues and potential solutions

The Risk and Resilience are currently working at half capacity due to the departure of Risk Management Team Leader. Recruitment for Head of Risk and Resilience post has started, once in place a work plan will be developed to ensure the team is achieving its aims.

The Risk and Resilience Department is now part of the Security Directorate. Over the coming months the team will become acquainted with this new management structure through the development of a new reporting structure.

4.3 Future areas of work and potential service developments

Resilience will be a focus of the Head of Risk and Resilience as work on plans was delayed due to Covid-19 and lack of staff in the team. The Head will also help develop the team and make plans for the future by working alongside the Security Director and the other heads of department to ensure the department is fully resourced and able to achieve its aims.

The next annual report will be submitted to the Audit Committee in September 2022 with the Board submission thereafter.

4 RECOMMENDATION

The Board is invited to note the Risk and Resilience Annual Report for the period 2020/21.

Paper No. 21/82

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	The Risk Management Annual Report provides the board with an update of the activity of the department over the last year in line with governance arrangements.
Workforce Implications	There are no workforce implications related to the publication of this report. The report provides information on various workforce factors including Complaints, RIDDOR and Training.
Financial Implications	There are no financial implications related to the publication of this report. The report provides financial information on Claims.
Route To Board Which groups were involved in contributing to the paper and recommendations	Audit Committee
Risk Assessment (Outline any significant risks and associated mitigation)	There are no significant risks related to the publication of the report. Significant incidents over the financial year are highlighted.
Assessment of Impact on Stakeholder Experience	There is no impact on stakeholder experience with the publication of this report.
Equality Impact Assessment	The EQIA is not applicable to the publication of this report.
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do)	The Fair Scotland Duty is not applicable to the publication of this report.
Data Protection Impact Assessment (DPIA) See IG 16	Tick One ✓ There are no privacy implications. ☐ There are privacy implications, but full DPIA not needed ☐ There are privacy implications, full DPIA included

THE STATE HOSPITALS BOARD FOR SCOTLAND

Risk and Resilience Annual Report

2020-2021

Prepared by: Risk Management Facilitator
Head of Risk and Resilience
Risk Management Project Support Officer

Approved by: Head of Risk and Resilience and presented to Audit Committee in September 2021

Contents

1. Risk Management Department
1.1 Introduction
1.2 Aims and Objectives

2. Governance
2.1 Committees/Groups

3. Key Work Activities (2020/21)
3.1 Risk Management
3.1.1 Changes within Department
3.1.2 Corporate Risk Register
3.1.3 Departmental/Local Risk Registers
3.2 Resilience
3.2.1 Resilience Plans
3.2.2 Resilience Related Incidents
3.2.3 Training and Exercising
3.2.4 NHS Standards for Organisational Resilience
3.3 Health & Safety
3.3.1 Control Book Audits
3.3.2 2019/20 Audit Summary
3.3.3 Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR)
3.4 Fire
3.5 Incident Reporting
3.5.1 Datix Incidents
3.5.2 Incident "Type" Trends over last 5 years
3.5.3 Risk Assessment
3.6 Enhanced Adverse Event Reviews
3.7 Training
3.7.1 Health & Safety Awareness
3.7.2 Manual Handling
3.7.3 Fire Safety
3.7.4 Level 1 PMVA
3.7.5 Level 2 PMVA
3.7.6 Workshop on Raising Awareness of Prevent (WRAP)
3.8 Freedom of Information (FOI) responses

4. Summary
4.1 Areas of Good Practice
4.2 Identified Issues and Potential Solutions
4.3 Future Areas of work and Potential Developments

5. Next Review Date

1. Risk Management Department

1.1 Introduction

The Risk and Resilience Department (Formerly Risk Management) is now part of the Security, Facilities and Estates Directorate (Previously under the Finance and Performance Directorate) and is involved in a range of functions from the maintenance of risk registers, development and review of Resilience Plans, Incident Reporting and Enhanced Reviews, Health & Safety, Duty of Candour and the administration of Datix.

1.2 Aims and Objectives

- Development, implementation and review of Risk and Resilience policies and procedures;
- Proactive identification of risks potentially impacting on The State Hospital (TSH), with the subsequent management of these risks through recognised risk management tools and techniques;
- Implementation of Incident Review processes to ensure significant adverse events are adequately investigated with the development of Action Plans to enhance organisational learning; and
- Supporting a "Quality" culture by developing staff competencies and improving risk management practices within TSH.

2. Governance

2.1 Committees/Groups

The Audit Committee has overall responsibility for evaluating the system of internal control and corporate governance, including the risk management strategy and related policies and procedures.

Risk management has been embedded within a variety of TSH committees, with regular reports on risk activity been presented to the Security, Risk & Resilience, Health and Safety Groups. Relevant incidents, the corporate risk register and policy management are also reported to the Audit, Clinical Governance and Staff Governance Committees on a quarterly basis.

Supporting committees include:

- ***Health, Safety and Welfare Committee** operates in partnership with staff, and plays a key role in monitoring and reviewing Health and Safety incidents and policy implementation.
- The committee reports issues to the **Staff Governance** Committee after each meeting and the minutes are circulated at the **Audit Committee**.
- **Hospital Management Team** and **Organisational Management Team** are new group structures within The State Hospital. Risk and Resilience have a presence at both these meetings to provide updates on current risk and resilience work as well as receive and monitor actions. Both of these groups feed into the **Corporate Management Team.**
- ***Resilience Committee** monitors and reviews progress on emergency and resilience plans, ensuring that core plans are in place, tested and reviewed, with the minutes being reported to the CMT.
- **Patient Safety Group** for which a report is prepared separately on an annual basis for Clinical Governance Committee.

*At time of reporting, these groups were in the process of being absorbed by the larger Security, Risk & Resilience and Health & Safety Committee.

3. Key Work Activities (2020-2021)

3.1 Risk Management

3.1.1 Changes within Department

During 2020/21 various changes were made within the department following a review by senior management:

Change of Name and Directorate

Following an internal review of Directors portfolios, the Risk Management Department was moved from the Finance and Performance Directorate to the Security, Estates and Facilities Directorate. The department was renamed the Risk and Resilience Team to reflect new roles and the focus of the department.

Change in Management Structure

In December 2020 the Risk Management Team Leader left post. Recruitment began in March 2021 for a new post – Head of Risk and Resilience with an aim to have the position filled by the end of May 2021. The post reports directly to the Director of Security, Estates and Facilities and work alongside the Head of Security and Head of Estates. As a result, the Risk Management Facilitator worked in a promoted post since December 2020 – Interim Risk Management Team Leader.

Complaints and Claims

The State Hospital complaints and claims function has been managed by the Board Secretary under Corporate Services since December 2020. The Complaints and Claims Officer also moved from Risk Management to continue their role, due to the removal of this role and service within the department the team member was not replaced. The Risk and Resilience Team continues to provide Datix administrative support to the Complaints as part of their function as Datix Administrators.

Merger of Committees

The Health and Safety Committee, Resilience Committee and Risk Management Group underwent a process of merging into one larger oversight group, and this was an ongoing workstream at the close of the financial year (meaning actions taken over by the Hospital Management Team/Organisational Management Team or relevant sub Group).

3.1.2 Corporate Risk Register (Appendix A)

A corporate risk is a potential or actual event that:

- interferes with the achievement of a corporate objective/target; or
- would have an extreme impact if effective controls were not in place; or
- is operational in nature but cannot be mitigated to acceptable level of risk

The corporate risk register has been in existence since 2005 with incremental changes being made as risk exposure changes. In February and March 2012, board members and hospital managers participated in two, half-day workshops to review and update the Corporate Risk Register to ensure that it continued to reflect the risk profile of the organisation following the move to the new hospital. A report was published in April 2012, and presented to the Audit Committee. The Corporate Risk Register was evaluated by internal audit and a report published in January 2016. This was reviewed by the Audit Committee. The frequency of risk review and detail contained within the Corporate Risk Register has been reviewed and updated.

The hospital's risk register process was subject to internal audit in February 2019 with the final report presented in March 2019. 10 recommendations were made, 5 graded as low, 5 graded as medium. RSM have closed off 9 out of the 10 actions with a final action awaiting confirmation of closure.

Action	Priority	Estimated Completion	Current Status
The current version of the Risk Register does not currently record any assurances that have been received. This is important to support the assessment of the current risk score/ comfort over the effectiveness of the controls.	Medium	30 April 2021	Assurances have been added to the Risk Assessment form and have been updated on all current risk register risk assessments. Evidence has been sent to RSM and is awaiting sign off

3.1.3 Department/Local Risk Registers

Department/Local Risk Registers contain risks that are particular to a specific department, are within the capability of the local manager to manage and are monitored and reviewed by the Head of Department. All departments are expected to develop a Local Risk Register, together with relevant risk assessments and action plans (if indicated).

The Head of Department will inform the relevant Executive Director of their departmental/local risks and indicate those risks to be reviewed (by exception) for inclusion to the Corporate Risk Register. This will include all current very high and high graded risks. The Head of Department is also responsible for developing, reviewing, and updating the local Risk Register.

Updates to LRR

The Risk Management Facilitator spent time training and working alongside Heads of Departments to update and create a new Local Risk Register. Following this work each department now has an active Local Risk Register, this is stored on the Microsoft Teams Channel to allow easy and regular updating of the risk assessments. The LRR is reported to various committees throughout the hospital and there is a clear route of escalation to the Corporate Risk Register should there be any increase in level of risk via the hospital management teams. This process will continue throughout the year with the Risk Management Facilitator meeting with heads of department regularly to ensure assessments are up to date and fit for purpose as well as assist with any training requirements.

3.2 Resilience

The Security Director is responsible for the management of Resilience within TSH and will also chair the Security, Risk and Resilience Health and Safety Group when it is up and running, The Security Director previously chaired the Resilience Committee. The Risk Management Department also produces an annual report for the Boards' Audit Committee.

3.2.1 Resilience Plans

TSH currently has the following plans in place to deal with the impact of the following situations:

Level 2 Incident Resilience Plans	Review Date	Incident Command Plans
Adverse Weather Conditions	October 2022	Part One Resilience and Emergency Planning Framework
Covid-19 Extreme Loss of Staff Plan	April 2023	
E-Health Resilience Plan	June 2020	

<table>
<tr><td>Electrical Supply Failure</td><td>March 2020</td><td rowspan="5">Part Two
Incident Command Manual

- Section A: Guide for Incident Commanders

- Section B: Checklists and Actions</td></tr>
<tr><td>Heating Systems Failure</td><td>September 2022</td></tr>
<tr><td>JANUS Failure</td><td>October 2017</td></tr>
<tr><td>Lack of Food Supplies</td><td>September 2022</td></tr>
<tr><td>Laundry Provision Interruption</td><td>January 2020</td></tr>
<tr><td>Lockdown of Site Plan</td><td>September 2020</td><td rowspan="2">Part Three
Level 2 Incident Resilience Plans</td></tr>
<tr><td>Loss of Control Room</td><td>October 2020</td></tr>
<tr><td>Loss of Patient Accommodation</td><td>September 2022</td><td rowspan="8">Part Four

Level 3 Incident Emergency Plans

- Siege
- Escape
- Fire
- Intruder
- Abscond</td></tr>
<tr><td>Loss of Staff</td><td>March 2023</td></tr>
<tr><td>Pandemic Influenza Contingency Plan</td><td>January 2022</td></tr>
<tr><td>Procurement Department</td><td>April 2020</td></tr>
<tr><td>Shortage of Fuel Plan</td><td>September 2020</td></tr>
<tr><td>Shortage of Pharmaceutical Supplies</td><td>May 2022</td></tr>
<tr><td>Telecommunications Failure</td><td>September 2022</td></tr>
<tr><td>Water Supply Failure</td><td>September 2022</td></tr>
</table>

During 2020/21, the Risk Management Facilitator carried out a review of the TSH Level 2 Resilience Plans, with the findings being as follows:

- Covid-19 Extreme Loss of Staff Plan was produced in light of the Covid-19 situation at the end 2019/20, review of this will take place once pandemic declared over alongside Pan Flu and Loss of Staff Plan to ensure learning is captured.
- 8 Level 2 Resilience Plans currently require to be reviewed.

Work on the plans was delayed due to ongoing staffing struggles across the hospital due to Covid-19 and specifically staffing issues within the Risk and Resilience Department. Once recruitment is completed for the Head of Risk and Resilience a programme will be developed for 2021/22 to progress plan reviews and a testing schedule agreed.

3.2.2 Resilience Related Incidents

In line with the approved Resilience Framework all resilience related incidents are reported via Datix, with Level 2 and 3 incidents being reported directly to the Resilience Committee.

The Incident levels are defined within the Resilience Framework as follows:

Level 1: Incidents which cause minor service disruption with one area/department affected which can be contained and managed within the local resources

Level 2: Incidents which cause significant service disruption, interruption to hospital routine, special deployment of resources and affect multiple areas/departments.

Level 3: A major/emergency situation which seriously disrupts the service and causes immediate threat to life or safety. These incidents will require the involvement of the Emergency Services

Since 2015, the number of Level 2 and 3 resilience related incidents reported to the Resilience Committee are as follows:

	2016/17	2017/18	2018/19	2019/20	2020/21
Level 2	6	7	4	2	0
Level 3	2	0	0	0	3

Three Level 3 incidents were reported to the Resilience Committee, which was still in place during 20/2021, the details of which are as follows:

May
Incident involving patient requiring external assistance to ensure safe resolution. Incident Command structure was established to deal with incident. Incident was subject to further investigation with a Category 1 Review being commissioned thereafter.

July
Incident involving patient requiring external assistance to ensure safe resolution. Incident command structure was established. Incident was subject to further investigation with a Category 1 Review being commissioned thereafter.

October
Incident involving patient requiring external assistance to ensure safe resolution. Incident command structure was established. Incident was subject to further investigation with Category 2 Review being commissioned thereafter.

3.2.3 Training and Exercising

The Resilience Committee previously planned and reviewed exercises in relation to resilience. This will be a focus of the new Head of Risk and Resilience and will be monitored by the Security, Risk and Resilience and Health and Safety Group.

Police Scotland

No Police Scotland test exercises took place in 2020/21. It has been difficult to facilitate these types of exercises due to Covid-19 restrictions and pressure on the services. Planning for this will take place in 2021/22.

Following a Cat 1 recommendation the Security and Risk and Resilience Team have been working with Police Scotland to support the position of a Police Liaison Officer for the hospital. Work is ongoing to complete this.

Incident Command – 'Golden Hour' training

One 'Golden Hour' session was delivered during 2020/21 to refresh existing staff and provide training to new staff fulfilling the role of senior clinical cover/security manager. Other planned sessions were unable to begin due to Covid-19 Restrictions. Future sessions are planned alongside some additional training provided by the Security Department.

Incident command was stood up multiple times throughout the year allowing staff to put into practice previous learning. Debriefs and Category 1 and 2 Reviews provided the hospital with a chance to hear feedback and use incidents as a learning opportunity.

Level 2 Exercises

Extreme Loss of Staff plan was developed due to the ongoing Covid-19 pandemic situation. This is used in conjunction with the Loss of Staff plan and Standard Operating Procedures should staffing levels drop to even more severe levels.

Planned exercises and testing for Level 2 exercises were unable to be completed due to the Covid-19 restrictions at the time. The Head of Risk and Resilience will progress this once in post.

Level 3 Plans

Work was unable to progress on the continued development of Level 3 plans due to pressures on the emergency services during the Covid-19 pandemic. Work on this will restart as restrictions begin to relax and the NHS returns to normal service.

During 2020/21 the hospital experience multiple Level 3 situations which required external support. Each incident was subject to a Cat 1/2 Review which provided a chance to review the policies and procedures in place to manage these types of incidents.

3.2.4 NHS Standards for Organisational Resilience

In May 2018, the Scottish Government updated its "NHS Scotland: Standards for Organisational Resilience document (2016), to reflect changes within the health and social care context, new policy imperatives and newly identified "Best Practice". This document specified minimum standards and related measure/performance indicator criteria for resilience within NHS Boards across Scotland.

TSH's Lead for resilience (Security Director) has responsibility for ensuring these Standards are achieved and are monitored by TSH Security, Risk and Resilience and Health and Safety Group.

The Security, Risk and Resilience and Health and Safety Work plan for 2020/21 is currently being reviewed as plans for the group continue to progress.

3.3 Health & Safety

3.3.1 Control Book Audits

Health & Safety electronic Control Books (eCB's) provide the infrastructure to manage Health & Safety arrangements across TSH.

TSH currently operate circa 41 eCB's hosted on TSH's intranet which are usually audited within a 2-year cycle to ensure compliance with organisational and local policies and procedures including but not exclusive to recording, progressing and escalation of 'Health & Safety' issues and identification of new or emerging hazards and associated risks.
Covid restrictions impacted ability to schedule Control Book audit programme during 2020/21.

3.3.2 2020/21 Audit Summary

23 control books were initially identified for audit during the 2020/21 Control Book audit programme, in line with the two year audit plan.
A revised audit programme identified 17 control books for audit from Quarter 3, 2020/21 with modified control book audit format to comply with Covid restrictions. This format heavily relied on electronic Control Book content and availability of Control Book Holders for remote 1:1.

Quarter 1 and 2 audit activity was suspended in response to Covid restrictions.
Ongoing restrictions on classroom training delivery and availability of staff to attend training / facilitate audit process has impacted progress of 2020/21 audit programme.

Control Book arrangements and responsibilities within Hub shared office accommodation were clarified as Security Managers. Hub shared accommodation control books were deferred to allow Security manager to attend Control Book training prior to audit.

Resultant eCB audit scores were released by email to Control Book Holders with detailed feedback on audit findings and recommendations to improve quality of evidence within the eCB.

One Control book failed to achieve an acceptable score on both aspects of audit, Control Book Holder requested refresher training prior to re-audit.

Department/	CB Audit	RA Audit
6 'new' or previously deferred Control Books		
Clinical Administration including Hub reception	0%	0%
Family Centre	81%	95%
Allied Health Professionals	87%	80%
Forensic Network	No progress in identifying Control Book Holder / Control Book Arrangements	
Psychology	No progress in identifying Control Book Holder / Control Book Arrangements	
Psychiatry	No progress in identifying Control Book Holder / Control Book Arrangements	
6 Control Books with 18/19 eCB and RA audit score 61 - 80%		
Lewis 3	Desktop audit complete- 1:1 deferred	
Mull 2	82%	87%
Estates	90%	98%
HR	Request to defer Control Book audit due to Control Book Holder long term absence	
Skye Centre Heath Centre	93%	84%
Physical Security	Agreement to defer	

Five further Control Books were identified for audit and Control Book Holders contacted to schedule appointments, however audit activity was suspended in line with new and emerging priorities in response to further Covid restrictions.

Department	
2x Control Books with 18/19 eCB audit and risk assessments scores >81%	
Learning and Development	Audit programme suspended
Communications	Audit programme suspended
2x Control Books with 19/20 audit scores 61-80%	
Management Centre	Audit programme suspended
Gardens	Audit programme suspended
1 x Control Books with 19/20 eCB audit score 61-80% and risk assessments score >81%	
Main Kitchen & Staff Dining Room	Audit programme suspended

Key Findings

- Improved implementation of previous audit feedback recommendations/advice
- Improved compliance with requirement to inspect Workplace/ Healthcare waste/ Fire safety arrangements on a quarterly basis
- Positive action on identifying Control Book Holders for areas of shared responsibility
- Ongoing limitations to local orientation evidence for Students and Junior Doctors
- Ongoing development of additional eCB section should facilitate evidencing safe working procedures for TSH staff working on non TSH premises
- Identifying and training DSE assessors to improve compliance with requirements of DSE Regulations suspended due to Covid restrictions

- Ongoing restrictions on classroom training delivery and availability of staff to attend training / facilitate audit process impacted progress of 2020/21 audit programme.

Recommendations
There are a number of new Control Book Holders with outstanding training needs.
With ongoing restrictions in classroom training delivery and staff availability to attend training, review the audit programme to determine if focus of audit activity should move from outstanding books to established control books to allow progression of subsequent audit programmes.

Audit format should also be reviewed to ensure it continues to meet the organisations 'needs'.

3.3.3 Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR)

RIDDOR requires employers to report incidents that 'arise out of or in connection with work resulting in: the death of any person; specified injury to any person or hospital treatment to non-employees; employee injuries resulting in over 7-day absence from work; dangerous occurrences and specified occupational diseases'. There has been decrease of 6 in reported RIDDOR incidents in comparison to 2019/20.

	Q1	Q2	Q3	Q4	2020/21	2019/20	2018/19
'Specified' Injuries*	0	1	1	0	**2**	**1**	**1**
Over 7 day lost time Injury	1	0	1	0	**2**	**9**	**27**
Total	1	1	2	0	**4**	**10**	**28**

3.4 Fire

Three fire alarms occurred during the year to which two received a response from Scottish Fire & Rescue Service. On one occasion, this was due to contractor work of drilling holes in the ceiling resulting in the alarm being sounded. The other two were instances where the fire alarm was activated with no obvious signs of smoke or flames.

3.5 Incident Reporting

Datix is the hospital's electronic incident reporting system, and is accessible to all staff via the intranet and a link from each computer desktop in the hospital.

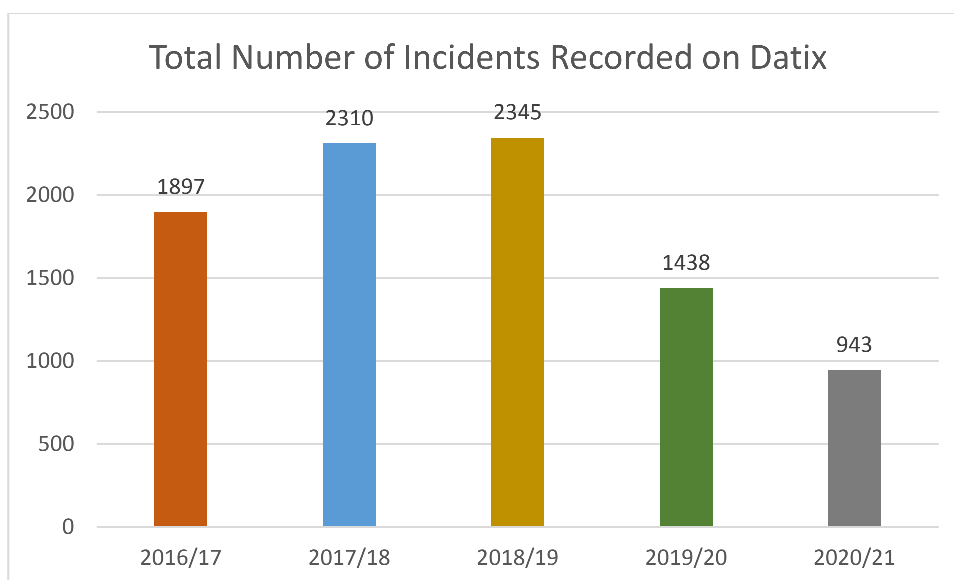
Each reported incident is investigated locally to ensure appropriate remedial and preventative steps have been taken. There are clear processes in place to identify incident trends or significant single incidents.

Datix classifies 7 overarching 'Type' of incident:

- Health and Safety
- Security
- Direct Patient Care
- Other
- Equipment, Facilities & Property
- Communication/Information Governance
- Infection Control

3.5.1 Datix Incidents

943 incident reports were finally approved during 2020/21; a significant decrease in the number of incidents finally approved in 2019/20 (1435). The chart below shows the changes in the number of incidents reported within Datix over the last 5 years.



3.5.2 Incident 'Type' Trends over last 5 years

Incident Type	2016/17	2017/18	2018/19	2019/20	2020/21
Health & Safety	974	1219	1095	712	**413**
Security	324	326	396	138	**93**
Direct Patient Care	269	270	214	146	**142**
Other	58	231	426	219	**115**
Equipment/Facilities/Property	166	175	117	106	**78**
Communication/Information Governance	70	66	51	32	**48**
Infection Control	36	23	46	82	**55**
Totals	**1897**	**2310**	**2345**	**1435**	**943**
*Average Patient Population	114	109	107	106	114

* based on bed compliment at end of each quarter/4

In comparison with the figures for 2019/20, there has been a reduction in the number of incidents reported during 2020/21 related to: Health & Safety (42%); Security (33%); Direct Patient Care (3%); Other (47%); Equipment/Facilities/Property (26%) and Infection Control (33%). However, there has been an increase in the number of incidents related to Communication / Information Governance (50%).

The number of incidents recorded in 2020/21 is lowest recorded since inception of Datix (excluding first year) with incidents decreasing in most categories, notably a reduction of 300 in the Health and Safety category, a 43% decrease. This decrease may have been impacted by the change in clinical care due to the Covid-19 pandemic as well as the reduction in staff onsite however an even larger decrease was noted in the previous year prior to Covid-19. Monitoring of this situation will continue throughout 2021/22.

3.5.3 Risk Assessment

The process of Risk Assessment within TSH involves the consideration of two key factors, i.e. likelihood (e.g. rare, unlikely, possible, etc.) of a given event occurring and the impact (or consequence) that the event may have on the organisation (e.g. financial, reputational, operationally, regulatory, etc.).

Likelihood	Potential Consequence				
	Negligible	Minor	Moderate	Major	Extreme
Almost Certain	Medium	High	High	Very high	Very high
Likely	Medium	Medium	High	High	Very high
Possible	Low	Medium	Medium	High	High
Unlikely	Low	Medium	Medium	Medium	High
Rare	Low	Low	Low	Medium	Medium

The following table provides details of the number of "high" graded risk incidents reported since 2016/17, which are consistently low.

Year	No. of "High" Graded Risk Incidents
2016/17	4
2017/18	3
2018/19	4
2019/20	1
2020/21	0

3.6 Enhanced Adverse Event Reviews

All incidents/near misses assessed as being a Very High (red) risk, will result in a Level 1 Review. Other incidents may be subject to a Level 1 review at the request of CMT/Clinical Team.

Level 1 is the most rigorous type of incident review, using root cause analysis to ensure appropriate organisational learning. At least one appropriately trained reviewer, supported by a member of the risk management department, will undertake Level 1 investigations.

Level 2 Reviews are utilised for less serious incidents, whereby, an in-depth investigation is required to identify any learning points and to minimise the risk of the incident recurring. The Review is carried out by an appropriately trained member of the Risk Management Team, with the aim to establish the facts of an incident quickly with a target to report back to the CMT within 45 days of the terms of reference being agreed.

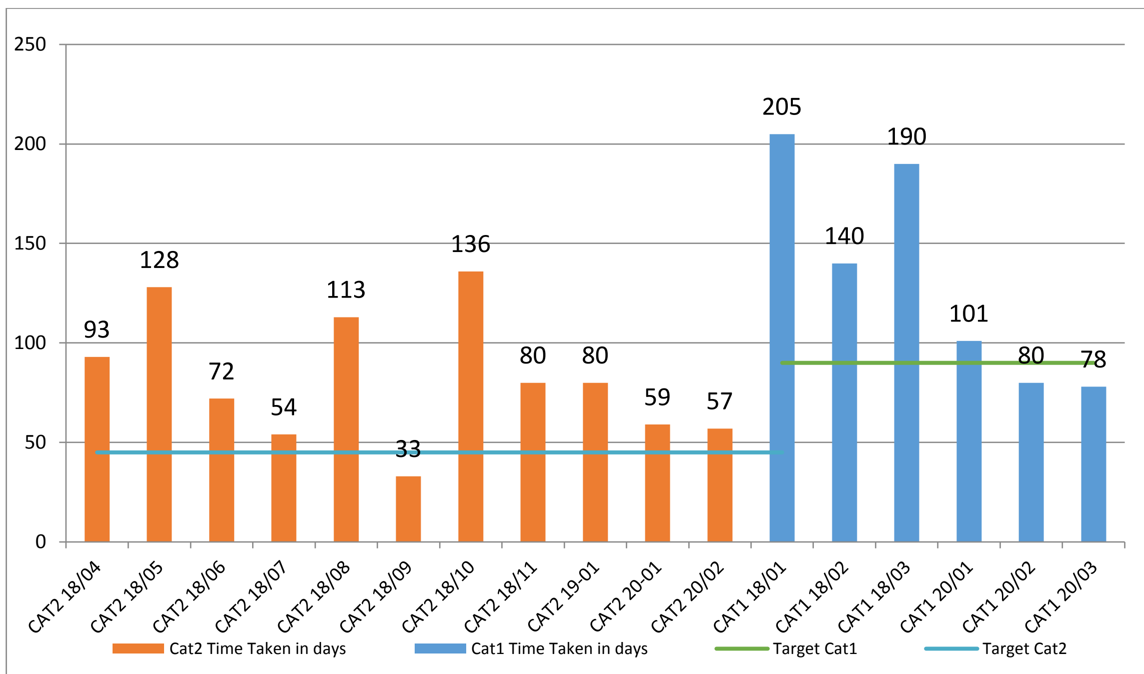
Three Category 1 Reviews were commissioned during 2020/21

- Cat 1 20/01 – Incident Command
- Cat 1 20/02 – Incident Command
- Cat 1 20/03 – Patient Death

Two Category 2 Reviews were commissioned during 2020/21 -

- Cat 2 20/01 – Self Harm
- Cat 2 20/02 – PS Incident

The graph below shows the length of time taken to complete the various Enhanced Adverse Event Reviews from approval of the terms of reference to the report being agreed by CMT.



3.7 Training

3.7.1 Health & Safety Awareness Training

At 31 March 2021, overall compliance for Health & Safety Awareness training was 92.2% (a decrease of 2.8% from 2019/20).

There were no Health & Safety Awareness training courses delivered during 2020/21 due to the suspension of face-to-face training in response to COVID-19. To support the continued delivery of this training, a new elearning programme was introduced at the end of January 2021. A total of 24 staff completed the new Health & Safety Essentials online learning programme during February/March 2021.

3.7.2 Manual Handling Training

At 31 March 2021, manual handling training had been completed by 99.1% of staff, (a decrease of 0.7% from 2019/2020)

Of this total, 98.5% *of* staff had completed the Manual Handling Essentials online training programme, with 90.8% of this group fully compliant with the bi-annual refresher requirements. In addition, 84.3% of staff had completed Level 2 Practical Training in Safer Manual/Patient Handling (a decrease of 5.8% from the previous year).

During 2020/21 a total of 434 staff completed the Manual Handling Essentials online training programme. Delivery of Level 2 Safer Manual/Patient Handling courses was limited during 2020/21 due to suspension of face-to-face training in response to COVID-19, and a total of only 8 staff completed Level 2 practical manual handling training during this period.

3.7.3 Fire Safety Training

At 31 March 2021, a total of 99.5% of staff had completed fire safety awareness training (no change from 2019/20).

A total of 576 staff completed the fire safety awareness training module during 2020/21. As of 31 March 2021, 86.3% of staff were fully compliant with annual refresher training requirements (an increase of 5.7% from 2019/20), 13.7% were overdue annual refresher training and 0.5% had still to complete the online module.

3.7.4 Level 1 PMVA Training

Level 1 ‘Personal Safety & Breakaway’ training is mandatory for non-clinical staff, with refresher training provided every 2 years. At 31 March 2021, 100% of staff in the target group had completed Level 1 ‘Personal Safety & Breakaway’ induction training. A total of 74.4% of staff within the target group were fully compliant with Level 1 PMVA refresher requirements (a decrease of 20.2% from 2019/20) and 25.6% were overdue refresher training.

During 2020/21 delivery of PMVA Level 1 ‘Personal Safety & Breakaway’ training was significantly impacted by the suspension of face-to-face training as a result of COVID-19.
A total of 13 courses were delivered during 2020/21 with a total of 95 attendees – including 61 staff plus 34 ‘external’ delegates (e.g. students and volunteers).

3.7.5 Level 2 PMVA Training

Level 2 ‘Prevention & Management of Violence & Aggression’ training is mandatory for all clinical staff employed under TSH terms & conditions, with refresher training provided every 2 years. At 31 March 2021, 99.7% of staff within the target group had completed Level 2 ‘Prevention & Management of Violence & Aggression’ induction training. A total of 88.8% of staff within the target group were fully compliant with PMVA Level 2 training requirements (a decrease of 7.4% from 2019/20) and 11.1% were overdue refresher training.

During 2020/21 delivery of PMVA Level 2 refresher training was significantly impacted by the suspension of face-to-face training as a result of COVID-19. A total of 18 refresher courses were delivered with 115 attendees. In addition, a further 21 new staff attended PMVA Level 2 induction training.

3.7.6 Workshop on Raising Awareness of Prevent (WRAP) Training

At 31 March 2021, WRAP training had been completed by 66.3% (a decrease of 1.9% from 2019/20).

There were limited WRAP training courses delivered during 2020/21 due to suspension of face-to-face training in response to COVID-19 and a total of 20 staff attended WRAP training.

3.8 Freedom of Information (FOI) Responses

The State Hospital changed the mechanism of recording FOI requests as from 1 April 2019. Instead of reporting the number of applications received we are now reporting the number of questions asked.

During 2020/21 the Risk Management Team received 0 FOI requests.

4. Summary

4.1 Areas of Good Practice

In addition to the positive outcomes highlighted throughout the report, there are a number of additional areas of good practice in relation to risk management across the hospital including:

- Effective monitoring of risk information by groups and committees
- Regular monitoring of patient-specific risks by clinical teams
- Strong evidence on learning from incidents, with local action being taken to minimise recurrences

Areas of good practice within the risk management department include:

- Continued development of the Corporate Risk Register with risk owners
- Updated Local Risk Register work completed and continued development in place
- Completion of implementation of RSM recommendations
- Support to Covid-19 Support Team throughout pandemic.

- Risk Management Facilitator has completed Root Cause Analysis Training to ensure at least one member of the team is fully trained as per policy.
- Risk Management Facilitator has been able to take on role of Interim Risk Management Team Leader whilst recruitment takes place.
- Improved delivery of Cat 1 and 2 reports, ensuring they are completed on time.

4.2 Identified issues and potential solutions

The Risk and Resilience are currently working at half capacity due to the departure of Risk Management Team Leader. Recruitment for Head of Risk and Resilience post has started, once in place a work plan will be developed to ensure the team is achieving its aims.

The Risk and Resilience Department is now part of the Security Directorate. Over the coming months the team will become acquainted with this new management structure through the development of a new reporting structure.

4.3 Future areas of work and potential service developments

Resilience will be a focus of the Head of Risk and Resilience as work on plans was delayed due to Covid-19 and lack of staff in the team. The Head will also help develop the team and make plans for the future by working alongside the Security Director and the other heads of department to ensure the department is fully resourced and able to achieve its aims.

5. Next Review Date

The next annual report will be submitted to the Audit Committee in September 2022.

Appendix A: Corporate Risk Register

Ref No.	Category	Risk	Initial Risk Grading	Current Risk Grading	Target Risk Grading	Owner	Linked Corporate Objective	Governance Committee	RA ?	AP	Monitoring Frequency
Corporate CE 10	Reputation	Severe breakdown in appropriate corporate governance	Extreme x Possible	Extreme x Rare	Extreme x Rare	Chief Executive	Better Care	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	Better Care	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	Better Care	Risk, Finance & Performance 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	Better Care	CMT	Y/Y	N/A	6 monthly
Corporate CE 14	Strategic	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	Better Care	CMT	Y/Y	N/A	Fortnightly
Corporate MD 30	Medical	Failure to prevent/mitigate obesity	Major x Likely	Major x Likely	Moderate x Unlikely	Medical Director	Better Health	Clinical Governance Committee	Y/Y	Y/Y	Monthly
Corporate MD 32	Reputation	Absconsion of patients	Major x Unlikely	Major x Rare	Moderate x Rare	Medical Director	Better Care	CMT	Y/Y	N/A	Quarterly
Corporate MD 33	Medical	Potential adverse impact arising from clinical presentation out of hours	Moderate x Unlikely	Moderate x Unlikely	Moderate x Unlikely	Medical Director	Better Care	CMT	Y/Y	N/A	Quarterly

		with no doctor on site (5pm - 6pm)										
Corporate MD 34	Medical	Lack of out of hours on site medical cover	Major x Unlikely	Major x Unlikely	Major x Unlikely	Medical Director	Better Care	CMT	Y/Y	N/A	Quarterly
Corporate MD 35	Medical	Non-compliance with Falsified Medicines Directive	Moderate x Unlikely	Moderate x Unlikely	Moderate x Rare	Medical Director	Better Health	Medicines Committee	Y/Y	N/A	Quarterly
Corporate SD 50	Service/ Business Disruption	Serious Security Incident	Moderate x Possible	Moderate x Possible	Moderate x Possible	Security Director	Better Care	CMT	Y/Y	N/A	Quarterly
Corporate SD 51	Service/ Business Disruption	Physical or electronic security failure	Extreme x Unlikely	Extreme x Unlikely	Extreme x Unlikely	Security Director	Better Care	Audit Committee	Y/Y	Y/Y	Monthly
Corporate SD 52	Service/ Business Disruption	Resilience arrangements that are not fit for purpose	Major x Unlikely	Major x Unlikely	Major x Rare	Security Director	Better Care	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 Unlikely	Extreme x Unlikely	Security Director	Better Care	Audit Committee	Y/Y	Y/Y	Monthly
Corporate SD 54	Service/ Business Disruption	Climate change impact on The State Hospital	Minor x Possible	Moderate x Possible	Minor x Possible	Security Director	Better Care	SMT/Resilience Committee	Y/Y	N/A	Quarterly
Corporate SD 55	Service/ Business Disruption	Negative impact of EU exit on the safe delivery of patient care within The State Hospital	Moderate x Unlikely	Moderate x Unlikely	Moderate x Rare	Chief Executive	Better Care	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	Better Care	CMT	Y/Y	Y/Y	Monthly
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	Better Care	CMT	Y/Y	Y/Y	Monthly

Corporate ND 72	Service/ Business Disruption	Failure to evolve the clinical model, implement and evidence the application of best practice in patient care	Moderate x Possible	Moderate x Possible	Moderate x Unlikely	Director of Nursing & AHP	Better Care	CMT	Y/Y	N/A	Quarterly
Corporate ND 73	Service/ Business Disruption	Lack of SRK trained staff	Moderate x Likely	Moderate x Possible	Moderate x Unlikely	Director of Nursing & AHP	Better Care	PMVA group & CMT	Y/Y	N/A	Quarterly
Corporate FD 90	Financial	Failure to implement a sustainable long term model	Moderate x Unlikely	Moderate x Unlikely	Moderate x Rare	Finance and Performance Director	Better Value	Audit Committee & CMT	Y/Y	N/A	Quarterly
Corporate FD 91	Service/ Business Disruption	IT system failure/breach	Moderate x Possible	Moderate x Possible	Minor x Possible	Finance and Performance Director	Better Value	Information Governance Group & CMT	Y/Y	N/A	Quarterly
Corporate FD 93	Health & Safety	Failure to complete actions from Cat 1/2 reviews within appropriate timescale	Moderate x Possible	Moderate x Possible	Moderate x Unlikely	Finance and Performance Director	Better Care	CEBM, CMT	Y/Y	N/A	Quarterly
Corporate FD 95	Service/ Business Disruption	Lack of IT on-call arrangements	Moderate x Possible	Moderate x Unlikely	Moderate x Unlikely	Finance and Performance Director	Better Care	CMT/Resilience Committee	N/A	N/A	Quarterly
Corporate FD 96	Service/ Business Disruption	Cyber Security/Data Protection Breach due to computer infection	Moderate x Unlikely	Moderate x Unlikely	Moderate x Unlikely	Finance and Performance Director	Better Care	SMT/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	Major x Possible	Major x Unlikely	Finance and Performance Director	Better Value	Information Governance Group & CMT	Y/Y	Y/Y	Monthly
Corporate HRD 110	Resource	Failure to implement and continue to develop the workforce plan	Moderate x Possible	Moderate x Possible	Minor x Rare	Interim HR Director	Better Workforce	CMT	Y/Y	N/A	Quarterly
Corporate HRD 111	Reputation	Deliberate leaks of information	Major x Possible	Major x Likely	Moderate x Unlikely	Interim HR Director	Better Care	SMT	Y/Y	Y/N	Monthly

Corporate HRD112	Health & Safety	Compliance with Mandatory PMVA Level 2 Training	Major x Unlikely	Major x Unlikely	Major x Rare	Interim HR Director	Better Care	H&S Committee	Y/Y	N/A	Quarterly

NHS SCOTLAND

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	28 October 2021
Agenda Reference:	Item No: 19
Sponsoring Director:	Chief Executive
Author(s):	Board Secretary
Title of Report:	Complaints Annual Report – 2020/21
Purpose of Report:	For Noting

1 SITUATION

NHS Boards are required to produce annual reporting relating to 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 through the Person Centred Improvement Team – this includes annual reporting as well as individual stories from patients and carers.

This report will provide the Board with a summary of activity within complaints handling for the year 1 April 2020 to 31 March 2021.

2 BACKGROUND

The NHS Model Complaints Handling Procedure (MCHP) 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.

The State Hospital (TSH) has appointed the Board Secretary to act as Complaints Manager for the organisation, supported by the Complaints and Legal Claims Officer and the Corporate Services Team.

Independent advice is also available through the Patient Advisory Service (PAS) with their representative being available on site to enable access and support for patients.

This report relates to the period 1 April 2020 to 31 March 2021 during a pandemic situation. However, TSH did manage to continue deliver a full complaints handling service providing a means for patient views to be heard, and responded to, in what has been a difficult and challenging time.

3 ASSESSMENT

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

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

Stage 2 investigation responses are escalated to and signed off by the Chief Executive.

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.

Early Resolution

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,

During this year it was possible to maintain an onsite complaints presence, with the Complaints Officer coming on site weekly and meeting directly with patients (subject to infection control measures in place throughout). This was particularly helpful in facilitating early resolution.

The PAS is based on site and has also been able to regularly support patients to resolve issues through early resolution.

Complaints Received

TSH received 42 complaints this year**.** Due to the nature of the environment, as a long-term health care setting, stakeholders may submit more than one complaint during the year e.g. eight patients made more than one complaint this 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	2018/19	2019/20	2020/21
Total Number Received	61	52	42
Average number of Patients throughout the year	107	106	111
Number of Complainants	35	21	24

Complaints Closed

A total of 43 complaints were closed this year. Complaints closed are categorised as either being upheld, not upheld or partially upheld.

The table below shows the number of complaints closed at each stage this year and the previous two years. Complaints received but then subsequently withdrawn are not included in the closed data.

Complaints Closed	2018/19	2019/20	2020/21	% (of all closed)
Stage 1 (Early Resolution)	36	30	31	72%
Stage 2 (Investigation)	14	7	7	16%
After Escalation to Stage 2	12	6	5	12%
Total	62	43	43	100%

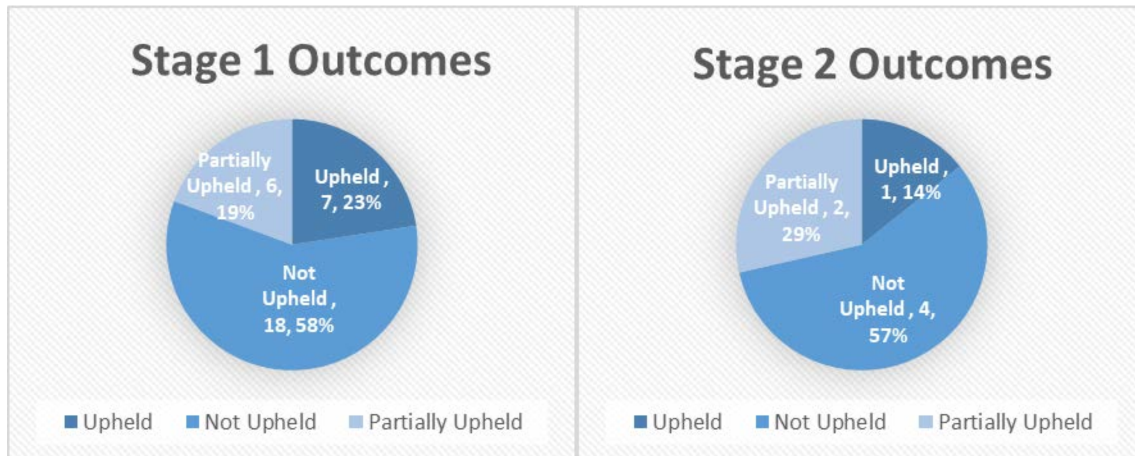
Complaint Outcomes

During this year, further steps have been put in place to sense check complaint outcomes through the Complaints Manager. 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 and charts below provide performance data relating to the outcomes of complaints closed during 202/21, which is then split into each stage pf the process. Data is also provided on a comparative basis with previous years.

Complaint Outcomes	2018/19	2019/20	2020/21	% (of all Outcomes)
Upheld	31	8	8	19%
Not Upheld	29	29	25	58%
Partially Upheld	2	6	10	23%
Total	62	43	43	100%

Outcomes at Stage 1 and Stage 2 in 2020/21:



Comparative outcomes at each stage:

Stage 1 - Early Resolution	2018/19	2019/20	2021/21	As % of all S1
Upheld	17	7	7	23%
Not Upheld	18	19	18	58%
Partially Upheld	1	4	6	19%
Total	36	30	31	100%

Stage 2 - Investigation	2018/19	2019/20	2020/21	As % of all S2
Upheld	9	1	1	14%
Not Upheld	4	4	4	57%
Partially Upheld	1	2	2	29%
Total	14	7	7	100%

After Escalation to Stage 2	2018/19	2019/20	2020/21	% of all escalated
Upheld	5	0	0	n/a
Not Upheld	7	6	3	60%
Partially Upheld	0	0	2	40%
Total	12	6	5	100%

Response Times

TSH continues to adhere to the MCHP guidelines with the target 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.

Average Number of Days	2018/19	2019/20	2020/21
To resolve at Stage 1	3	3	4
To respond to a complaint at Stage 2	13	18	20
To respond to a complaint after escalation to Stage 2	17.5	20	17

The tables below show our performance in responding to complaints at each stage within the MCHP target response times. Whilst extensions to the MCHP 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.

Closed within the target timescales	2018/19	2019/20	2020/21
Closed at Stage 1 within 5 working day target	32	29	27
as % of the total number closed at Stage 1	89%	97%	87%
Closed at Stage 2 within 20 working day target	22	8	10
as % of the total number closed at Stage 2	85%	62%	83%

Not closed within the target timescales	2018/19	2019/20	2020/21
Closed at Stage 1 after the 5 working day target	4	1	4
as % of the total number of Stage 1 closed	11%	3%	13%
Closed at Stage 2 after the 20 working day target	4	5	2
as % of the total number of Stage 2 closed this year	15%	38%	17%

Focus on Quality

An internal quality assurance process has been established to ensure compliance with the requirements of the MCHP. As detailed within this report, performance timescales and recording of outcomes are quality checked by the Complaints Manager.

For formal investigation responses (Stage 2) a process has been put in place through which the response is prepared by the Complaints Officer, based on staff witness statements and feedback. This is reviewed by the Complaints Manager to ensure that the response is of a sufficient quality and that it comprehensively answers the concerns raised. The Director(s) responsible for the service(s) involved are then 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.

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 (72%) were resolved at Stage 1 during this year. Most of these were quickly 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

- Recurring issues raised related to *Staff Attitude/Behaviour/Conduct* (40%) and *Clinical Treatment* (14%) similar to previous years and accounting for 55% of all issues raised. Both subjects showed a decrease; with issues relating to Clinical Treatment decreasing by over half.
- *Communication* accounted for 12% of issues raised. These related to social media, recruitment, the gender of staff and oral/written communication.
- *Catering Service* issues showed an increase this year accounting for 12% of all issues raised, compared to 1% last year. Catering services were initially impacted by the pandemic and some temporary changes were made to the service to accommodate this.

Some complaints do result in changes in practice and examples of this are provided in the table below.

Issues Raised	Outcome	Output
Concern re contact with carers and opportunity for video visiting.	Visits suspended due to breach of protocol. Visitor contact number not on record.	The Clinical Team introduced new forms to record all agreed contact details and communication of protocol.
Special dietary requirements not being catered for.	The patient was selecting from a mix of options from the standard menu and a special diet. This meant on some occasions the meal chosen was not appropriate for their needs.	Dietician input helped changes to the patient's meal plan to reflect their dietary needs. New system introduced for delivery of special diet meals.

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. Depending on the impact of national restrictions, the Complaints Officer has met with patients whenever possible, and subject to national guidelines on physical distancing.

Staff continue to 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 Complaints and Feedback training modules – the compliance rate for this was 85% at the end of March this year. In addition to the online modules, a complaints awareness session forms part of the induction day programme for all new staff. Due to the pandemic induction sessions were put on hold. To combat this, training was provided to help staff develop methods of providing sessions online. Details of complaints received relating to medical staff form part of their appraisal process, enabling staff to discuss these fully at their annual appraisal.

The main issues arising and learning taken from complaints are communicated through Staff Bulletins.

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 capture learning from this, a local feedback pro-forma is available to help to seek feedback from everyone using the complaints process. It is acknowledged that this does not usually elicit many responses - three responses were received this year.

Questions	2018/19	2019/20	2020/21
Finding information about how to make a complaint was easy	22	7	3
Making a complaint was easy	24	7	3
Staff were helpful, polite and professional	23	8	3
Staff listened and understood my complaint	22	8	3
Staff asked what I expected to happen as a result of making the complaint	17	5	1
Staff explained the complaints process to me	16	7	1
The letter advising me of the decision was easy to read & understandable	19	7	2
All my issues were answered	17	7	2
I raised concerns about how my complaint was handled	10	3	0

This feedback is provided anonymously, unless the complainant decides to provide details. This can create a challenge in terms of understanding more about the issue(s) and learning from experience. As a long-term health care setting, it is to be expected that multiple complaints may be received from the same person, who may not wish to complete the feedback form on each occasion.

Scottish Public Services Ombudsman (SPSO)

Complainants who remain unhappy with the response to their complaint from TSH can ask the SPSO to review their complaint.

During 2020/21 one enquiry was received from the SPSO in relation to a complaint made during the year. Details of the complaint file were shared with the SPSO, who did not request any further information or raise a concern in this regard.

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. There was no requirement for this service to be used during 2020/21.

Patient Advisory Service

PAS 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 and would benefits from advocacy on their behalf. During 202/21 PAS supported 18 complaints which represents 43% 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 MCHP 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. During the year, as part of a review of the TSH management structure, responsibility for the complaints service moved to the Corporate Services Team led by the Board Secretary who is the TSH Complaints Manager.

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 has also received reporting on complaints throughout this period 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.

Service Development

There is continued focus on delivery the aims of the MCHP 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 workstreams the MCHP 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 have been asked to identify staff groups who would benefit from this, and two areas of focus have been highlighted. Firstly, to deliver training to staff who may be involved in complaints investigations at a local level, focussed on the MCHP. 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 necessarily been delayed due to covid restrictions and staff resourcing, and it will be progressed as soon as possible.

Development of the service also requires recognition of the need for resilience. Given its size and the low number of complaints received, TSH has one dedicated Complaints Officer. However, as the service is now managed within Corporate Services, training is also being provide within the team to help build knowledge and resilience in this area. This includes the opportunity of external complaints training as well as shadowing the Complaints Officer/ Manager within TSH.

4 RECOMMENDATION

The Board is invited to:

1. Note assurance on delivery of the MCHP 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. Note the key aims for development of the service in the current year 2021/22.
4. Advise of any change in reporting structure or additional reporting required for future reporting.

Paper No 21/ 83

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	The MCHP introduced a standard approach to managing complaints across NHS Scotland which complies with the Scottish Public Services Ombudsman (SPSO) and meets all the requirements of the Patient Rights (Scotland) Act 2011. Reporting measures performance and delivery 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

NHS SCOTLAND

THE STATE HOSPITALS BOARD FOR SCOTLAND

APPROVED Minutes of the meeting of the Audit Committee held on Thursday 17 June 2021 at 9.45am via Microsoft Teams A(M)21/03

PRESENT:

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

IN ATTENDANCE:

Internal	
Interim Board Chair	David McConnell
PA to Director of Finance and eHealth	Fiona Higgins ***(Minutes)***
Chief Executive	Gary Jenkins
Director of Finance and eHealth	Robin McNaught
Head of Corporate Planning and Business Support	Monica Merson
Board Secretary	Margaret Smith
External	
Client Manager, RSMUK	Sue Brooke
Partner, Azets	Chris Brown
Director, Azets	Karen Jones
Head of Internal Audit, RSMUK	Asam Hussain

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

Brian Moore welcomed everyone to the meeting. Apologies for absence were noted from David Walker, Director of Security, Estates and Resilience.

Brian Moore advised that items 13, 16, 17 and 18 would be presented to a special Audit Committee to be convened on 22 July 2021 due to a delay with the production of the Annual Accounts whilst we await a notification from the Scottish Government in relation to PPE cost adjustments.

2 CONFLICTS OF INTEREST

There were no conflicts of interest to note.

3 MINUTES OF THE PREVIOUS MEETING

The Minutes of the previous meeting held on 25 March 2021 were amended at page 5 to read Azets and subsequently approved as an accurate record.

4 MATTERS ARISING – ACTION PLAN UPDATE

Progress was noted on the Minute action points with item 1 delayed due to covid19, items 2 and 3 noted as complete; and item 4 not yet available.

APPROVED

INTERNAL AUDIT

5 INTERNAL AUDIT ANNUAL REPORT 2020/21

Asam Hussain presented the Internal Audit Annual Report for the period 2020/21 to members. The report provided an annual internal audit opinion based upon and limited to the work performed on the overall adequacy and effectiveness of the Hospital's risk management, control and governance processes, with the positive opinion contributing to the organisation's annual governance reporting. Throughout the period there were six reviews undertaken with three receiving reasonable assurance; one partial assurance (recording of absence and additional hours to SSTS) and two advisory reviews.

Sue Brooke advised the Committee that management and staff were always willing to help and provide input during audits and with the completion of recommendations.

Appendix A provided the annual opinions; Appendix B gave a summary of the audit work completed with the assurance level attained also noted and Appendix C provided members with the opinion classification.

Members noted the Internal Audit Annual Report for 2020/21.

6 INTERNAL AUDIT PLAN 2021/22 – PROGRESS REPORT

Asam Hussain presented an update to Members on the delivery of the Internal Audit Plan for 2021/22 and advised members that work had completed on 27 May 2021 in relation to the SSTS Rostering audit, however due to the responsible Directors absence there would be a delay in presenting this to the Committee, members were content with this delay and noted the content of the report presented.

7 INTERNAL AUDIT TRACKING REPORT 2021/22

The Committee received and noted the tracking report from RSMUK in relation to management actions taken forward in response to internal audit recommendations. Of the 23 actions reviewed:

- 5 are implemented
- 7 are not yet due for implementation
- 7 superseded
- 2 in progress
- 2 no response received *(received following issue of report)*

Sue Brooke advised that the 7 superseded actions relate to the Rostering and Scheduling of Workforce audit undertaken in 2020 and assured members that these actions have been followed up and incorporated within the more recent Effective Rostering and Overtime Management audit which is currently with management for agreement.

Members noted the update of the internal audit action tracker.

8 RECORDING OF ABSENCE AND ADDITIONAL HOURS TO SSTS

Sue Brookes presented the internal audit report on the Recording of Absence and Additional Hours to SSTS, this audit had been agreed following a payroll review undertaken in September 2019 where anomalies were identified between timesheets / rotas and hours entered into SSTS. During this audit it was concluded that there are no procedure documents to guide what information is required to support the recording of absence or additional hours worked to SSTS, with inconsistencies noted across the Hospital. This audit highlighted that the management actions raised as a result of the payroll review in September 2019 had not been implemented. The audit report details a number of recommendations and provides a partial assurance.

APPROVED

Gary Jenkins advised that he will take this forward with the Directors and provide feedback to the Audit Committee on the development of an auditable process for recording of absence and additional hours to SSTS.

ACTION: GARY JENKINS

Members noted the internal audit report and the action agreed to address the findings.

9 eHEALTH REVIEW

Sue Brookes presented the advisory audit report on the eHealth Function, this audit had been agreed to assess the skills, resourcing and capacity of the eHealth function to support and deliver on the operational and strategic requirements of the Board. The review identified that the eHealth Function is still in the process of developing and defining their approach to delivery IT services across the Hospital and noted a lack of formalised process for managing or capturing information relating to asset replacement strategies; performance levels and capacity issues, however it was noted that the volume of information and the demands placed upon the team have evolved and the impact of remote working has exacerbated this further. A number of key areas for management to focus upon, to formalise and enhance current process were identified. The work was of an advisory nature and therefore no formal assurance opinion is received. Members noted an amendment at page 4 of the report where March 2020 should read March 2021.

Members noted the content of the report and were content that no high level actions were recommended and observed that the small eHealth Team at the Hospital were very proactive but are a finite resource pulled in lots of different directions, particularly during the Covid19 period where they excelled in the provision of facilitating remote working and increased ehealth demands across the Hospital.

Robin McNaught highlighted that over the previous 18 months actions have been taken to address the resourcing issues in the department which should allow the Head of eHealth to focus on the strategic elements of his role. The report has been helpful in finalising the eHealth Strategy and informing the departments new structure.

Gary Jenkins commented that over a number of years there had been a lack of prioritisation of the eHealth Department which is now being addressed, particularly to allow resourcing of national requirements, including NIS Audits and to resource the elements of the eHealth strategy.

Brian Moore noted this as a helpful report and asked that Robin McNaught feedback to the eHealth Team support from the senior managers across the Hospital in implementing the eHealth Strategy.

ACTION: ROBIN McNAUGHT

ANNUAL REPORTS FROM GOVERNANCE COMMITTEES

10 CLINICAL GOVERNANCE COMMITTEE

The Committee received the annual report from the Clinical Governance Committee for 2020/21, and agreed that this detailed report provided assurance that the Committee was fulfilling its remit, and that adequate and effective clinical governance arrangements were in place throughout the year.

Members received and noted the annual report which will be presented to the Board this afternoon for approval.

APPROVED

11 STAFF GOVERNANCE COMMITTEE

The Committee received the annual report from the Staff Governance Committee for 2020/21 and agreed that this detailed report provided assurance that the Committee was fulfilling its remit and that adequate and effective staff governance arrangements were in place throughout the year.

Members received and noted the annual report which will be presented to the Board this afternoon for approval.

12 REMUNERATION COMMITTEE

The Committee received the annual report from the Remuneration Committee for 2020/21 and agreed that this detailed report demonstrates that the Committee has discharged its responsibilities.

Members received and noted the annual report which will be presented to the Board this afternoon for approval. Acknowledging that the terms of reference are not always consistent across NHS

13 AUDIT COMMITTEE

Members agreed that the annual report of the Audit Committee should be deferred to the 22 July 2021 meeting.

SERVICE AUDITS

14 NATIONAL SINGLE INSTANCE (NSI) AND NSS SERVICE AUDITS

The Committee received a report to provide an update on the service audits carried out on the NSS National IT Services Contract, by KPMG and National Single Instance (NSI) Finance System, by BDO UK. Members were advised that NHS Ayrshire and Arran are the host Board for NSI.

Both NSS and NHS Ayrshire and Arran have provided Boards within copies of their Service Audits so that Boards can gain assurance of the operation of systems on their behalf and Robin McNaught advised the Committee that no high risk recommendations were identified. Full reports are available on request.

Members noted the opinions on the reports.

15 AUDIT SCOTLAND NATIONAL REPORTS

The Committee received a report to provide an update of the recommendations made following publication of Audit Scotland National Reports published since the previous Audit Committee. There has been one Audit Scotland Reports issued relevant to the State Hospital since the last update.

The report summarised the content of the NHS in Scotland 2020 published in February 2021 which provided an update on the annual performance of the NHS and its future plans. A full copy of the report is available on the Audit Scotland website and members were encourage to read this. The main highlights from the report are in relation to the Covid19 pandemic and the remobilisation plans with key recommendations noted in the report.

Members noted the receipt of the national reports.

APPROVED

EXTERNAL AUDIT

16 EXTERNAL AUDIT ANNUAL REPORT TO THE BOARD AND THE AUDITOR GENERAL FOR SCOTLAND

Members agreed that this item be deferred to the 22 July 2021 meeting.

STATUTORY ANNUAL ACCOUNTS

17 STATUTORY ANNUAL ACCOUNTS

Members agreed that this item be deferred to the 22 July 2021 meeting.

ANNUAL AUDIT COMMITTEE ASSURANCE STATEMENT TO THE BOARD

18 ANNUAL AUDIT COMMITTEE ASSURANCE STATEMENT

Members agreed that this item be deferred to the 22 July 2021 meeting.

OTHER ISSUES

19 WAIVER OF SFIs TENDERING REQUIREMENTS

The Committee received a report from the Director of Finance and eHealth, to outline any instance during 2020/21 whereby the Chief Executive and Director of Finance and eHealth have agreed to waive the requirement for competitive tendering or quotations should they jointly agree that it is not possible or desirable to undertake same due to timescale, specialist expertise, completion of an existing project, or a supply continuity benefit whilst giving regard for all circumstances, and in accordance with Standing Financial Instructions (SFIs).

The Committee were asked to note that each case was closely reviewed to ensure that the use of a waiver was valid. The instances when one or more of these exceptions has been applied in the year to March 2021 were attached to the paper for the Committee's information. The total value of instances were in line with the 2018/19 period as a number of cyclical contract renewals were required which was not the case in 2019/20 which was correspondingly low. The Committee were asked to note that each case is closely reviewed to ensure that the use of a waiver is valid. As is generally expected for these waivers, the main items in the year related to Security, eHealth and Estates.

The Committee noted the use of waivers for tendering.

20 FRAUD UPDATE

A report was submitted by the Director of Finance and eHealth to provide an overview on fraud allegations and any notification received from Counter Fraud Services.

A significant number of alerts due to Covid19 had been issued since the last report and these were summarised within the report, all having been reviewed and circulated as appropriate with all newly reported approaches noted. Two new allegations were received since the March report, one has been investigated internally and is now closed, the other is currently under internal investigation.

The annual meeting with Counter Fraud Services took place last wek with our new CFS Champion, Stuart Currie in attendance. The annual letter to the Scottish Government confirming no fraud of concern has been signed by the chair of the Audit Committee and returned to the Scottish Government.

APPROVED

The Committee noted the alerts circulated by Counter Fraud Services in the last quarter and noted no updates on fraud allegations.

21 FRAUD ACTION PLAN

The Committee received and noted the paper which provided an update on Board engagement with Counter Fraud Services (CFS). The report detailed that all matters are on schedule/rearranged to be held virtually or complete.

Stuart Currie commented that the meeting with Counter Fraud Services had been informative and helpful.

A sickness absence related fraud guidance was also circulated for members information.

The Committee noted the progress on engagement activities; noted the update on Communication; reviewed the Fraud Action Plan (Appendix 1) and noted the revision of the Top Ten Risks identified from the FRAM (Appendix 2, which had been agreed and reviewed with CFS and FLO on Thursday 24 September 2020.

22 SUMMARY OF LOSSES AND SPECIAL PAYMENTS

The Committee received a report from the Director of Finance eHealth, which provided an annual review of the Board's register of losses and special payments. The paper summarised losses and special payments for the year and noted the decrease from the previous year, there being no significant elements requiring highlighting to the Committee.

The Committee were content to note the summary of recorded losses and special payments.

23 FINANCE, EHEALTH AND AUDIT GROUP MINUTES

Members received and noted the minutes from the Finance, eHealth and Audit Group meeting of 18 March 2021 and welcomed the changes to governance and structure.

24 SECURITY, RISK AND RESILIENCE, HEALTH AND SAFETY GROUP MINUTES

Members received and noted the minutes from the Security, Risk and Resilience, Health and Safety Group meeting of 28 April 2021 and welcomed the changes to governance and structure.

25 ANY OTHER BUSINESS

Robin McNaught advised that he would present a Cyber Security Report to each Audit Committee and periodically to the Board to address how we mitigate national and local risks.

ACTION: ROBIN McNAUGHT

26 DATE AND TIME OF NEXT MEETING

An additional meeting for approval of the annual accounts will take place on 22 July 2021 via Microsoft Teams.

The next full meeting of the Audit Committee will take place on Thursday 7 October 2021 at 9.45am via Microsoft Teams.

APPROVED

THE STATE HOSPITALS BOARD FOR SCOTLAND

APPROVED Minutes of the meeting of the Audit Committee (to approve annual accounts) held on Thursday 22 July 2021 via Microsoft Teams A(M)21/04

PRESENT:

Outgoing Interim Board Chair	David McConnell **(Chair)**
Non-Executive Director	Stuart Currie
Employee Director	Tom Hair
Incoming Board Chair	Brian Moore
Non-Executive Director	Pam Radage

IN ATTENDANCE:

<u>Internal</u>	
Chief Executive	Gary Jenkins
PA to Chief Executive	David McCafferty
Director of Finance and eHealth	Robin McNaught
Director of Security, Estates and Facilities	David Walker
PA to Director of Nursing, AHPs and Operations	Sharon Bruce **(Minutes)**
<u>External</u>	
Director, Azets	Chris Brown
	Victoria Gould
Head of Internal audit, RSMUK	Asam Hussain
Director, Azets	Karen Jones

1 APOLOGIES

David McConnell welcomed everyone to the meeting and opened by congratulating Brian Moore on his appointment as Chairperson to The State Hospital's Board for Scotland.

Apologies were received from Monica Merson and Margaret Smith.

2 CONFLICTS OF INTEREST

No conflicts of interest were recorded.

3 ANNUAL REPORT FROM GOVERNANCE COMMITTEE

Members noted the Audit Committee Annual Report 2020/21 which is presented in draft for approval to present at the Board meeting.

It was highlighted that this report makes reference to the completion of the patient funds audit however this has not yet been completed at this stage due to auditors not being permitted onsite during covid. Members were assured by Mr McNaught that processes are in place and a report on this work will be made available in due course.

The report concluded that based on the work that it has undertaken, the Committee has met in line with the Terms of Reference, has fulfilled its remit and is satisfied that internal controls are adequate to ensure that the Board can achieve the policies, aims and objectives set by Scottish Ministers, to safeguard public funds and assets available to the Board, and to manage resources efficiently, effectively and economically.

Members approved the report subject to the matter raised in relation to Patients Funds work.

APPROVED

4 EXTERNAL AUDIT

Members received the finalised External Audit Management Annual Report for year end 31 March 2021 which was presented by Chris Brown of Azets. This report highlights key risk areas and work required to address those risk. It was noted that there were no areas for concern for this audit period and that the External Auditors will issue an unqualified audit option on these accounts.

The following maters were identified during audit:

Treatment of unspent RRL
The draft annual report and accounts reported an amount £144,000 deferred which related to unspent RRL allocation. This sum has been treated as deferred income in the financial statements. The auditors reported that this should have been presented as an underspend in the year and approval sought from SGHSCD to carry this forward in to 2021/22. This has not been adjusted in the annual accounts and therefore an unadjusted audit different has been reported. The risk of this being that non-compliance with accounting standards and inaccurate reporting of financial performance.

Recommendation: The Board should review its accounting treatment in respect of unspent RRL.

Property, plant and equipment
During the audit the following areas were noted where there is scope for improvement as they relate to the Board's arrangements for maintaining its asset portfolio:

- Development of procedures on recording assets under construction on the fixed asset register once they become available for use.
- Development of procedures to review assets under constructions for impairment as the project progresses.
- Development of procedures for updating assets lives in the year the full asset valuation is carried out.
- Development of procedures over internal asset verification exercises during the year.

There is a risk that if such procedures are not developed and followed that the fixed asset portfolio is materially misstated in the financial statements.

Recommendation: Procedures should be developed covering the above areas.

Employee contracts
Not all employee contracts are signed. Continued employment is taken as implied acceptance of the terms of the contract.

Without a signed employee contract in place, the Board increases the risk of uncertainty surrounding the terms of the agreement which could result in a legal dispute.

Recommendation: All employee contracts should be signed prior to employment commencing.

Service Level Agreements
It was noted that in one instance there was no SLA in place. And one where the incorrect end date has been recorded on the SLA schedule.

By engaging a service provided without a signed SLA in place, the Board increases the risk of uncertainty surrounding the terms of the agreement which could result in a legal dispute. If the SLA schedule is not kept up to date, payment could be made/received after expiry of the signed agreement.

Recommendation: Signed SLAs should be obtained and kept for all service providers. The SLA schedule should be reviewed and updated on a regular basis.

APPROVED

The above recommendations have been assigned to Directors and timelines agreed to address throughout the coming year.

Query was raised in terms of why some boards are not making payments when balances are due despite follow up action being raised on numerous occasions. Gary Jenkins agreed to take forward negotiations with individual boards who have accepted transfer of patient to their health board area to seek resolutions in terms of transfer date and payment etc.

ACTION: GARY JENKINS

It was also highlighted that it has been difficult to track costs of PPE given the process of supplying this previously. It was suggested to be helpful for auditors to have discussions as to how this can be tracked in the future.

It was noted that the full Annual Audit Report, including wider-scope audit work, requires to be submitted to the Auditor General and Scottish Ministers by end September therefore it was agreed that Robin McNaught will discuss with Chris Brown and Karen Jones prior to the next Board to agree way forward.

The Chair thanked the Azets Team for their very thorough and comprehensive report.

Members noted the content of the report.

5 STATUTORY ANNUAL ACCOUNTS

Members received the Annual Report and Accounts for the year ending 31 March 2021 which was presented by Robin McNaught, Director of Finance and eHealth. It was noted that the Performance Report which was prepared in accordance with the FReM and complies with best practice was noted to be within budget.

The finance department, who worked effectively in collaboration with National Services Scotland and Azets during the accounts preparation and audit process, were thanked for their considerable efforts in compiling the Annual Report and Accounts..

Members were asked to review the report and recommend to the Board for final approval.

6 ANNUAL AUDIT COMMITTEE ASSURANCE STATEMENT TO THE BOARD

Members received a report from Robin McNaught in respect of the Annual Audit Committee Assurance Statement to the Board for 2020/21.

It was noted that the Audit Committee has received the results of the work of Internal Audit during the year 2020/21 and has considered the annual Internal Audit Report presented by the Chief Internal Auditor. The result of the Internal Audit was set out in a separate paper as presented to the Audit Committee in June 2021.

The Audit Committee has also received confirmation that the external auditors have completed their audit of the 2020/21 annual accounts and will issue an unqualified audit option on these accounts. The external auditors have also reviewed the Governance Statement.

Members noted that the assurance statement would inform the Board in its collective decision to:

- Approval and signing of the Performance report
- Approval and signing of the accountability report
- The approval and the adoption of the Annual Accounts which have been separately presented to this Committee and the Board for consideration.

APPROVED

It was noted that an amendment was required to the SBAR whereby the external auditors are named as Azets rather than Scott Moncreiff.

ACTION: FIONA HIGGINS

Members then approved the annual Audit Assurance Statement for 2020/21 for submission to the Board.

7 ANY OTHER BUSINESS

No other business was raised.

8 DATE AND TIME OF NEX MEETING

The next meeting is scheduled to take place on 7th October 2021 at 9.45am.

APPROVED

Paper No. 21/ 84

NHS SCOTLAND

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	28 October 2021
Agenda Reference:	Item No: 21
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 risk registers, to support oversight in this respect.

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 Assessment of Risks

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

HR Department Corporate Risks – Director of Workforce met with Risk Management Facilitator in October to discuss Corporate Risk Register and in the process of updating the risk assessments. Update to follow.

Following the Board meeting of August 2021, work is ongoing to update the Corporate Risk Register (Appendix A) to ensure all risks are aligned to the Board and its committee structure and the relevant executive management group at the right level to support governance. Further work is progressing on executive management alignment, given the changes in the structure and further updates will be presented through this report to the Board for assurance.

3.2 Proposed Risks for inclusion on Corporate Risk Register

N/A

3.3 Medium/High/Very High Graded Risks

The Register currently has 4 HIGH graded risks:

CE14 The risk that Coronavirus (Covid-19) could affect The State Hospitals primary aim to provide high quality, effective care and treatment and maintain a safe and secure environment for patients and staff
MD30 Failure to prevent/mitigate obesity
ND71 Failure to assess and manage the risk of aggression and violence effectively
ND70 Failure to utilise our resources to optimise excellent patient care and experience

The following 21 risks are graded as Medium:

*CE10 Severe breakdown in appropriate corporate governance
*CE11 Risk of patient injury occurring which is categorised as either extreme injury or death
CE12 Failure to utilise appropriate systems to learn from prior events internally and externally
MD32 Absconsion of patients
*MD33 Potential adverse impact arising from clinical presentation out of hours with no doctor on site (5pm - 6pm)
*MD34 Lack of out of hours on site medical cover
*SD50 Serious Security Incident
SD51 Physical or electronic security failure
SD52 Resilience arrangements that are not fit for purpose
*SD53 Serious security breaches (eg escape, intruder, serious contraband)
SD54 Climate change impact on The State Hospital
SD55 Negative impact of EU exit on the safe delivery of patient care within The State Hospital
SD56 Water Management
SD57 Failure to complete actions from Cat 1/2 reviews within appropriate timescale
ND73 Lack of SRK trained staff
FD90 Failure to implement a sustainable long term model
*FD91 IT system failure/breach
*FD97 Unmanaged smart telephones' access to The State Hospitals information and systems.
HRD110 Failure to implement and continue to develop the workforce plan
*HRD111 Deliberate leaks of information
HRD112 Compliance with mandatory PMVA Level 2 refresher training.

*target risk met

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

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

Risk level	Review cycle
Low risk	6 monthly
Medium risk	Quarterly
High risk	Monthly
Very High	Monthly

3.4 Risk Updates

CE14 The risk that Coronavirus (Covid-19) could affect The State Hospitals primary aim to provide high quality, effective care and treatment and maintain a safe and secure environment for patients and staff: Risk continues to be reviewed at CMT fortnightly, continues to remain at 'High'

ND70 Failure to utilise our resources to optimise excellent patient care and experience: Risk continues to remain at 'High' due to current staffing pressures within the hospital, monitored monthly as per guidance.

SD57 Failure to complete actions from Cat 1/2 reviews within appropriate timescale: Now responsibility of Security Directorate due to change in hospital structure, Risk and Resilience Department now reports to Director of Security, Estates and Facilities.

3.5 Risk distribution

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

4 RECOMMENDATION

The Board are invited to consider and review the current Corporate Risk Register, and to advise whether any changes or additions should be made.

MONITORING FORM

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

Paper No. 21/ 84

Appendix A

Ref No.	Category	Risk	Initial Risk Grading	Current Risk Grading	Target Risk Grading	Owner	Action officer	Next Scheduled Review	Governance Committee	RA	AP	Monitoring Frequency	Movement Since Last Report
Corporate CE 10	Reputation	Severe breakdown in appropriate corporate governance	Extreme x Possible	Extreme x Rare	Extreme x Rare	Chief Executive	Board Secretary	31/10/21	Board	Y/Y	N/A	Quarterly	-
Corporate CE 11	Health & Safety	Risk of patient injury occurring which is categorised as either extreme injury or death	Extreme x Possible	Extreme x Rare	Extreme x Rare	Chief Executive	Chief Executive	31/10/21	Clinical Governance Committee	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 Managem ent Team Leader	31/10/21	Audit Committee	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	30/11/21	Board	Y/Y	N/A	6 monthly	-
Corporate CE 14	ALL	The risk that Coronavirus (Covid-19) could affect The State Hospitals primary aim to provide high quality, effective care and treatment and maintain a safe and secure environment for patients and staff.	Major x Almost Certain	Major x Unlikely	Minor x Possible	Chief Executive	Chief Executive	01/11//21	Board	Y/Y		Fortnightly	-
Corporate MD 30	Medical	Failure to prevent/mitigate obesity	Major x Likely	Major x Likely	Moderate x Unlikely	Medical Director	Lead Dietitian	31/10/21	Clinical Governance Committee	Y/Y	Y/Y	Monthly	-
Corporate MD 32	Medical	Absconsion of Patients	Major x Unlikely	Major x Rare	Moderate x Rare	Medical Director	Associate Medical Director	31/10/21	Clinical Governance Committee	Y/Y	N/A	Quarterly	-
Corporate MD 33	Medical	Potential adverse impact arising from clinical presentation out of hours with no doctor on site (5pm - 6pm)	Moderate x Unlikely	Moderate x Unlikely	Moderate x Unlikely	Medical Director	Associate Medical Director	31/10/21	Clinical Governance Committee	Y/Y	N/A	Quarterly	-
Corporate MD 34	Medical	Lack of out of hours on site medical cover	Major x Unlikely	Major x Unlikely	Major x Unlikely	Medical Director	Associate Medical Director	31/10/21	Clinical Governance Committee	Y/Y	N/A	Quarterly	-

Corporate SD 50	Service/Business Disruption	Serious Security Incident	Moderate x Possible	Moderate x Possible	Moderate x Possible	Security Director	Security Director	30/11/21	Audit Committee	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	30/11/21	Audit Committee	Y/Y	Y/Y	Quarterly	-
Corporate SD 52	Service/Business Disruption	Resilience arrangements that are not fit for purpose	Major x Unlikely	Moderate x Unlikely	Moderate x Rare	Security Director	Security Director	30/11/21	Audit Committee	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	30/11/21	Audit Committee	Y/Y	Y/Y	Quarterly	-
Corporate SD 54	Service/Business Disruption	Climate change impact on the State Hospital	Minor x Possible	Moderate x Possible	Minor x Possible	Security Director	Head of Estates and Facilities	30/11/21	Audit Committee	Y/Y	N/A	Quarterly	-
Corporate SD 55	Service/Business Disruption	Negative impact of EU exit on the State Hospital	Moderate x Unlikely	Moderate x Unlikely	Moderate x Rare	Chief Executive	Security Director	30/11/21	Audit Committee	Y/Y	N/A	Quarterly	-
Corporate SD 56	Service/Business Disruption	Water Management	Major x Unlikely	Major x Unlikely	Major x Rare	Security Director	Head of Estates and Facilities	30/11/21	Clinical Governance 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	30/01/22	Audit Committee	Y/Y	N/A	Quarterly	-
Corporate ND 70	Service/Business Disruption	Failure to utilise our resources to optimise excellent patient care and experience	Moderate x Possible	Moderate x Likely	Minor x Unlikely	Director of Nursing & AHP	Director of Nursing & AHP	31/10/21	Audit Committee	Y/Y	Y/Y	Quarterly	Likelihood ↑
Corporate ND 71	Health & Safety	Failure to assess and manage the risk of aggression and violence effectively	Major x Possible	Major x Possible	Major x Possible	Director of Nursing & AHP	Director of Nursing & AHP	31/10/21	Audit Committee	Y/Y	Y/Y	Monthly	-
Corporate ND 73	Service/Business Disruption	Lack of SRK trained staff	Moderate x Likely	Moderate x Possible	Moderate x Unlikely	Director of Nursing & AHP	Director of Nursing & AHP	30/09/21	Clinical Governance Committee	Y/Y	N/A	Quarterly	-

Corporate FD 90	Financial	Failure to implement a sustainable long term model	Moderate x Unlikely	Moderate x Unlikely	Moderate x Rare	Finance & Performance Director	Finance & Performance Director	31/12/21	Audit Committee	Y/Y	N/A	Quarterly	-
Corporate FD 91	Service/Business Disruption	IT system failure/breach	Moderate x Possible	Moderate x Possible	Minor x Possible	Finance & Performance Director	Head of eHealth	31/12/21	Audit Committee	Y/Y	N/A	Quarterly	-
Corporate FD 94	Service/Business Disruption	Inadequate data centre	Moderate x Likely	Moderate x Rare	Moderate x Unlikely	Finance and Performance Director	Head of eHealth	31/03/22	Audit Committee	Y/Y	N/A	Quarterly	Likelihood ↓
Corporate FD 96	Service/Business Disruption	Cyber Security/Data Protection Breach due to computer infection	Moderate x Unlikely	Moderate x Rare	Moderate x Unlikely	Finance and Performance Director	Head of eHealth	30/11/21	Audit Committee	Y/Y	N/A	6 Monthly	-
Corporate FD 97	Reputation	Unmanaged smart telephones' access to The State Hospital information and systems.	Major x Likely	Moderate x Possible	Major x Unlikely	Finance and Performance Director	Head of eHealth	31/12/21	Audit Committee	Y/Y	Y/Y	Quarterly	Likelihood ↓
Corporate HRD 110	Resource	Failure to implement and continue to develop the workforce plan	Moderate x Possible	Moderate x Unlikely	Minor x Rare	Interim HR Director	Interim HR Director	31/08/21	Staff Governance Committee	Y/Y	N/A	Quarterly	-
Corporate HRD 111	Reputation	Deliberate leaks of information	Major x Possible	Major x Unlikely	Moderate x Unlikely	Interim HR Director	Interim HR Director	31/08/21	Board	Y/Y	Y/N	Quarterly	-
Corporate HRD 112	Health & Safety	Compliance with Mandatory PMVA Level 2 Training	Major x Unlikely	Moderate x Possible	Major x Rare	Interim HR Director	Training & Professional Development Manager	31/08/21	Staff Governance Committee	Y/Y	N/A	Quarterly	Impact ↓

NHS SCOTLAND

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	28 October 2021
Agenda Reference:	Item No: 22
Sponsoring Director:	Board Chair
Author(s):	Board Secretary
Title of Report:	Annual Schedule of Board and Sub Board Meetings – 2022
Purpose of Report:	For Decision

1 SITUATION

The Board requires to agree the schedule of meetings for 2022, and to make the dates of the board meetings publically available on its website.

2 BACKGROUND

The draft schedule of Board and Committee Meetings in 2022 has been circulated to all Board Members for comments and input.

3 ASSESSMENT

The draft Annual Schedule of Meetings for Board and Sub Board Committees in 2022 is attached as Appendix A. There are no proposed changes to the usual pattern of the schedule for Board and Committee Meetings.

It should be noted that the Audit Committee and Board meeting on the same day in June 2022, to allow full review of the annual accounting process. This meeting is proposed for 23 June, but it may be the case that a further meeting will require to be scheduled depending on the whether the annual accounts process has been finalised as planned.

The Remuneration Committee has been scheduled to meet three times later in the year, timed to ensure that the Executive and Senior Manager appraisal process is fully supported as well as Consultants Discretionary Points. In accordance with its terms of reference, the Remuneration Committee may stand up further meetings should members consider this to be appropriate. The schedule does not confirm the dates for the earlier part of the year as this is to be confirmed with members following agreement to re-schedule the final meeting for 2021. In spring 2022 there will be a requirement to review Executive and Senior Manager objectives for the current year, as well as to agree objectives for 2022/23.

4 RECOMMENDATION

Members are asked to decide if the attached Annual Schedule of Meetings for 2022 should be adopted.

Author:
Margaret Smith
Board Secretary
01555 842012

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	To ensure the TSH Board and its standing committees has schedule of meetings in place and can fulfil its remit in 2021. To ensure public awareness of meeting dates for the Board.
Workforce Implications	Work is progressed with executive management to ensure support of meeting structure.
Financial Implications	None to be considered
Route To Board Which groups were involved in contributing to the paper and recommendations.	Board requested item through its workplan
Risk Assessment (Outline any significant risks and associated mitigation)	This reports mitigates the risk of board committees not being able to fulfil their remit, failure of attendance /quorum if a schedule is not in place, failure to alert the public in good time to public board meetings.
Assessment of Impact on Stakeholder Experience	Stakeholders and wider public should be notified of the schedule of public board meetings.
Equality Impact Assessment	Full assessment is 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

NHS SCOTLAND

ANNUAL SCHEDULE OF MEETINGS - 2022

BOARD AND SUB-BOARD

MEETING	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEPT	OCT	NOV	DEC
BOARD*		**Thursday 24.02.22 10am**		**Thursday 28.04.22 10am**		**Thursday 23.06.22 1pm**		**Thursday 25.08.22 10am**		**Thursday 27.10.22 10am**		**Thursday 22.12.22 10am**
AUDIT COMMITTEE	**Thursday 27.01.22 9.45am**		**Thursday 17.03.22 9.45am**			**Thursday 23.06.22 9.45am**				**Thursday 06.10.22 9.45am**		
CLINICAL GOVERNANCE COMMITTEE		**Thursday 10.02.22 9.45am**			**Thursday 12.05.22 9.45am**			**Thursday 11.08.22 9.45am**			**Thursday 10.11.22 9.45am**	
STAFF GOVERNANCE COMMITTEE		**Thursday 17.02.22 9.45am**			**Thursday 19.05.22 9.45am**			**Thursday 18.08.22 9.45am**			**Thursday 17.11.22 9.45am**	
REMUNERATION COMMITTEE *						**Thursday 16.06.22 10am**			**Thursday 15.09.22 10am**			**Thursday 08.12.22 10am**

* The Board and Remuneration Committee may also meet as and when required

2022
PUBLIC HOLIDAYS:

New Year:	Monday 3 January & Tuesday 4 January	*Easter:*	Friday 15 April & Monday 18 April
Christmas:	Monday 26 December & Tuesday 27 December	*Autumn Holiday:*	Friday 23 September & Monday 26 September