THE STATE HOSPITALS BOARD FOR SCOTLAND

BOARD MEETING

THURSDAY 23 DECEMBER 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 28 October 2021	For Approval	TSH(M)21/10
4.	**Matters Arising:**		
	Actions List: Updates	For Noting	Paper No. 21/89
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. 21/90
b.	**Finance Update** Report by the Director of Finance & eHealth	For Noting	Paper No. 21/91
10.50am	**CLINICAL GOVERNANCE**		
8.	**What Matters to You 2021?** Report by the Director of Nursing, AHPs and Operations	For Noting	Presentation
9.	**Person Centred Improvement Service Report** Report by the Director of Nursing, AHPs and Operations	For Noting	Paper No. 21/92
10.	**Patient Advocacy Service Report** Introduced by the Director of Nursing, AHPs and Operations	For Noting	Paper No. 21/93
11.	**Quality Assurance and Quality Improvement** Report by the Head of Corporate Planning and Business Support	For Noting	Paper No. 21/94

12.	**Clinical Governance Committee** Approved minutes - meeting held 12 August 2021 Chair's Update – meeting held 11 November 2021	For Noting	CG(M)21/03
13.	**Clinical Forum** Approved minutes - meeting held 28 September Chair's Update – meeting held 23 November	For Noting	CF(M) 21/05
	*** BREAK 11.40am to 11.50am***		
11.50am	**STAFF GOVERNANCE**		
14.	**Achieving Safe Staffing** Report by the Director of Nursing, AHPs and Operations	For Noting	Paper No. 21/96
15.	**Attendance Performance Report** Report by the Director of Workforce	For Noting	Paper No. 21/97
16.	**Whistleblowing Reporting:** **-Quarter 2 Update** Report by the Director of Workforce	For Noting	Paper No. 21/98
			Paper No. 21/99
	-Whistleblowing Champion Update Board Secretary	For Noting	
17.	**Staff Governance Committee** Approved minutes - meeting held 19 August 2021 Chair's Update – meeting held 18 November 2021	For Noting	SG(M) 21/03
12.10pm	**CORPORATE GOVERNANCE**		
18.	**Finance Report to 30 November 2021** Report by the Director of Finance & eHealth	For Noting	Paper No. 21/100
19.	**Perimeter Security and Enhanced Internal Security Systems Project** Report by the Director of Security, Estates and Resilience	For Noting	Paper No. 21/101
20.	**Performance Report Q2 – 2021/22** Report by the Head of Corporate Planning and Business Support	For Noting	Paper No. 21/102
21.	**eHealth Reporting:** **-Annual Report 2020/21 (including Digital Inclusion Update)** Report by the Director of Finance & eHealth	For Noting	Paper No. 21/103
22.	**Information Governance – Annual Report 2020/21** Report by the Director of Finance & eHealth	For Noting	Paper No. 21/104
23.	**Communications – Annual Report 2020/21** Report by the Head of Communications	For Noting	Paper No. 21/105
24.	**Corporate Governance Improvement Action Plan** Report by the Board Secretary	For Noting	Paper No. 21/106

25.	**Board Workplan 2022** Report by the Board Secretary	For Decision	Paper No. 21/107
26.	**Corporate Risk Register** Report by the Director of Security, Resilience and Estates	For Decision	Paper No. 21/108
27.	**Any Other Business**		Verbal
28.	**Date of next meeting** 24 February 2022		Verbal
29.	**Proposal to move into Private Session, to be agreed in accordance with Standing Orders.** Chair	For Approval	Verbal
30.	**Close of Session and Reflection on Meeting**		Verbal

Estimated end at 1.pm

THE STATE HOSPITALS BOARD FOR SCOTLAND TSH (M) 21/10

Minutes of the meeting of The State Hospitals Board for Scotland held on Thursday 28 October 2021.

Meeting conducted virtually by way of MS Teams and commenced at10am.

Chair: Brian Moore

Present:

Employee Director	Allan Connor
Non-Executive Director	Stuart Currie
Non-Executive Director	Cathy Fallon
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
Social Work Team Leader	David Hamilton
Head of Corporate Planning and Business Support	Monica Merson
Board Secretary	Margaret Smith [Minutes]
Director of Security, Resilience and Estates	David Walker

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

Mr Moore welcomed everyone to the meeting, and apologies were noted from Dr Sheila Howitt (Chair of the Clinical Forum) as well as Ms Caroline McCarron (Head of Communications). He also noted that several members of staff had joined the meeting as observers.

2 CONFLICTS OF INTEREST

There were no conflicts of interest in respect of the business on the agenda. However, in respect of Item 10, Ms Fallon asked the Board to note her role as lay representative for NHS Education for Scotland. She advised that she did not have direct involvement in assessments meaning that there would not be a potential conflict of interest as a result of this role.

3 MINUTES OF THE PREVIOUS MEETING

The minutes of the previous meeting held on 26 August 2021 were agreed to be a full and accurate record of the meeting.

The Board:

1. Approved the minute of the meeting held on 26 August 2021: TSH(M)21/08.

4 ACTION POINTS AND MATTERS ARISING FROM PREVIOUS MEETING

The Board received the action list (Paper No. 21/70) 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 as Board Chair over the previous two-month period since the date of the last Board meeting.

A Board seminar had taken place on 23 September, which had supported helpful updates and discussion across a range of topics including safe staffing legislation and related workforce components, remobilisation planning as well as arrangements for public board meetings during the continuing restrictions due to the Covid-19 pandemic.

Mr Moore had also attended the Clinical Forum on the 28 September and found this interesting and informative.

Alongside the other NHS Chairs and NHS Chief Executives, he was involved in the weekly systems pressure meetings led by the Cabinet Secretary for Health and Social Care. These were focussed on the capacity within NHS Scotland as a whole and winter planning, and had particular relevance for The State Hospital(TSH) in the context of national recruitment challenges and the impact on staffing locally. Additionally, National Board Chairs were meeting fortnightly as a useful forum through which to share information and exchange ideas.

He underlined that NHS Scotland remained on an emergency footing until 31 March 2022, and noted that the Once for Scotland workforce policy framework was paused until April 2022.

Mr Moore confirmed that he had also taken part in a meeting with the Minister for Mental Health on 11 October, alongside Mr Jenkins and Mr Richards, to provide feedback to the Minister on how TSH was responding to challenges in staffing capacity within the nursing directorate, and to provide reassurance on the local actions being taken forward.

He had also visited the Staff Wellbeing Centre on site in the hospital, and met with the team, and had been pleased to see the support available for staff. He had also attended the Annual General Meeting of the Patient Advisory Service on 22 October.

Mr Moore advised that the positon of Whistleblowing Champion Non-Executive Director remained vacant on the TSH Board, and that further advice in this respect was expected through Scottish Government.

Finally, he noted that NHS Chairs were preparing a response to the public consultation on Adult Social Care. For TSH, this may have particular relevance by informing more widely on wider future governance arrangements and framework in NHS Scotland.

The Board:

1. Noted this update from the Chair.

6 CHIEF EXECUTIVE'S REPORT

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

He added to the update provided by the Board Chair, in relation to weekly systems pressures meetings, with the key pressure for TSH being staffing in terms of capacity and recruitment challenges within the national context. He highlighted the pressures within NHS Scotland for the provision of health serviced overall during the winter period, and the impact of additional funding through Scottish Government. Systems pressures were expected to be linked to national forecasting on the continuing impacts of Covid-19.

Mr Jenkins advised that other key areas of focus for NHS Chief Executives had been involvement in the planning for COP26 in Glasgow, as well as responding to the public consultation on a National Adult Care Service.

He underlined the challenge that TSH was facing in terms of staffing, and the actions taken on recruitment focussed on nursing staff. These included ongoing, proactive recruitment, and re-configuring the skills matrix required. This was work being taken forward in partnership and Mr Jenkins thanked Mr Connor and wider staff side colleagues for their helpful contribution in this regard. Work was progressing in relation to supplementary staffing and progress would be reported through the Staff Governance Committee given their oversight in this area. A development day had been arranged to support joint staff side on 8 November. He also echoed the Board Chair's feedback in relation to the meeting with the Minister for Mental Health and Wellbeing, which had been helpful and supportive. Mr Stewart had indicated his keen interest in visiting TSH and meeting the team as soon as it was possible to do so, dependent on Covid-19 restrictions.

Mr Jenkins asked the Board to note that the Staff Excellence Awards would take place on 30 November 2021, and advised that this would be through a digital link to encourage wide attendance.

Mr Jenkins noted that the Programme for Government 2021/22 had been published on 8 September, and that this had indicated that Scottish Government would provide a formal response to the Barron review. He added that immediate actions were being progressed particularly focussed on patient flow across the forensic estate, and assured the Board that he was linking with colleagues across the estate to progress this and take any immediate actions possible through agreement in the shorter term. The Board asked whether it was possible to be clearer on timescales at the present moment, and both Mr Jenkins and Professor Thomson advised that the formal response from Scottish Government was expected to be published imminently. Professor Thomson advised that the action plan, led by the Forensic Network, was being taken forward and was demonstrating progress in the provision of medium secure capacity. Mr Jenkins added that the Board would be kept advised in terms of the national direction of travel, and the key impacts for TSH.

In terms of the recruitment challenges, Ms Fallon also asked if there were any other key challenges being experienced more widely than in the nursing cohort, which was clearly under pressure nationally. Mr Jenkins advised that more detailed overview could be presented through the Staff Governance Committee – with a target operating model for the workforce component. This was agreed as a helpful way forward.

Action – Linda Davidson

<u>The Board:</u>

1. Noted the update from the Chief Executive.
2. Agreed that reporting on workforce target operation model should be routed through the Staff Governance Committee, and escalated to the Board if required.

7a COVID 19 RESPONSE - RESILIENCE REPORTING

A paper was received from the Chief Executive (Paper No. 21/71) 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, and provided key highlights form the report for members. In particular, he noted the ongoing development of the management structure across the hospital, as well as within the executive cohort, with wider organisational development support being sought through use of a strengths deployment inventory.

The TSH Remobilisation Plan, updated for the period to 31 March 2022 was submitted to Scottish Government on 30 September as required, and their response was expected shorty. The final agreed plan would be shared with the Board and published on the website thereafter.

He drew the Board's attention to the incident command arrangements put in place for a short period at the beginning of September, as well as the response to small outbreaks of Covid-19 within the hospital during September and October, which had been managed appropriately through an Incident Management Team, and had not to date indicated a high level of infection or transmission within the hospital.

Mr Jenkins provided the updated positon on the programmes for Covid-19 vaccination as well as Seasonal Flu. In answer to a question on the potential for enforcement within health and social care staff, Mr Richards advised that national mandating was not expected within NHS Scotland. Within TSH, 248 patient facing-staff had been offered the Covid-19 booster, and more widely staff would be sign-posted to community clinics as these became available.

Mr Jenkins asked the Board to note the work being progressed by Professor Thomson in terms of the possibility of providing a medical ward on site within TSH, especially given the ongoing developments made and complexity in the type of care offered to Covid-19 patients within an acute setting. He noted the work being progressed to ensure that an optimal experience could be provided to visitors, both in person and digitally, with updates in these areas to be provided to the next meeting of the Board.

Mr Jenkins summarised the section of the report relating to workforce, underlining the work being progressed on recruitment and that reporting would be guided through the Staff Governance Committee to enable detailed oversight in this area. He emphasised the continuing value of the wellbeing workstream, and that a strategy was under development.

Finally, Mr Jenkins noted the short term capacity challenge experienced within Communications and that Ms Smith's team had helpfully provided additional support for this area to ensure that the key elements of the service could be maintained.

Board members welcomed the report as an important and useful update, showing the ongoing challenges that Covid-19 presents to the delivery of services. Mr Currie asked a question on the on how TSH could benefit from the Digital Health and Care Strategy published by Scottish Government this week. Mr Jenkins advised that there were potential benefits and that this this was being led by Mr McNaught, with update reporting to be brought to the Board

Action: Mr McNaught

Mr Moore then summarised for the Board, endorsing its recommendations and that reporting should continue in this format. He added thanks to all staff for their continuing work and great efforts shown to support the delivery of care throughout, as the report had clearly demonstrated.

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. 21/72) to provide the Board with an update on reporting of specific Covid-19 related costs to Scottish Government.

Mr McNaught confirmed that reporting had been submitted to Scottish Government for the first two quarters of the financial year, along with forecasting for the final six-month period. In response, confirmation had been agreed by Scottish Government for funding in line with forecasting as well as that opportunity would be available for revision should there be variation. Regular contact was being maintained with Scottish Government to support detailed ongoing review especially given that it was to be expected that Covid-19 related costs would continue to this financial year end, with an indication that this may extend in the next financial year.

In answer to a question from Mr Moore on nursing costs as a potential concern, Mr McNaught confirmed that this was flagged and reported as part of forecasting as an area that could potentially be of concern in the future, though was not of immediate concern.

The Board:

1. Noted the content of the report, and of specific Covid-19 related costs reported to Scottish Government.

8 CLINICAL MODEL MAPPING

A paper was received from the Medical Director (Paper No. 21/73) to provide the Board with an update on the progress made in planning for the restart of implementation of the new clinical model.

Professor Thomson introduced this paper as a six-point plan on the way forward for engagement. She advised the Board that the re-start of this workstream was being positively welcomed by both patients and staff and that there was considerable interest in it. Ms Merson then led members through the detail contained within the report including re-visiting the mapping exercise previously undertaken in June 2021, emerging views from patients and staff, the Quality Improvement pathway, financial impacts and the wider governance framework supporting the workstream. She also highlighted the wider system considerations in terms of the forensic estate and system flow across NHS Scotland.

Mr Moore thanked Ms Merson and Professor Thomson and was pleased to see the sense of momentum building around this workstream. Mr McConnell asked about the impacts of unknowns in the national context e.g. a female pathway within TSH and how planning for the model could be affected. Mr Jenkins advised that any such service established within TSH would require a separate infrastructure, and the task at that point would be how to align a female service in parallel to an established male service. This would require national input in order to take that forward. Professor Thomson added that the ten ward model would not incorporate a female service which would require to be an eleventh ward. In this way, planning for the male service could continue to be progressed. This was supported by Mr Currie who noted the importance of service planning being capable of adjusting to change and flexing in different circumstances.

Professor Thomson added advice for the Board that a potential risk to the new model would be capacity in the wider system which affected patient flow, and the Board would be kept closely advised.

The Board considered the governance arrangements and agreed that regular reporting should continue to be brought to the Board during 2022, and this should be added to the workplan as a key area of interest.

The Board:

1. Noted the content of the report and update on the restart of the clinical model,

2. Endorsed the governance through the Clinical Governance Committee for detailed oversight as well as direct regular reporting to the Board during 2022.

9 CORPORATE PARENTING PLAN 2021-2023

A paper was received from the Director of Nursing, AHPs and Operations (Paper No. 21/74) which provided the Board with an update on Part 9 (Corporate Parenting) of the Children and Young People (Scotland) Act 2014. This placed responsibility on TSH to improve the lives and futures of Scotland's looked after children, young people and care leavers.

Mr Richards introduced this paper, confirming that TSH is one of 24 Corporate Parents as defined in the legislation. He thanked Mr Hamilton for his work in this area, which focussed on how to monitor progress in this area. Mr Hamilton detailed the key areas for the Board, acknowledging that activity was modest given the low numbers of patients within TSH that this affected.

Mr Moore recognised that despite the low numbers, it was nonetheless important to be assured that the right approach was being take, and Ms Fallon followed this with a question on whether any lessons had been learned to date in this area. Mr Hamilton responded that a key part of this had been recognising the need for raising awareness within the hospital of the responsibility placed on the organisation and being alert to this to ensure that those who fall under the remit of the legislation were not missed. This is especially important though aligning nursing and social work colleagues. He advised that it was difficult to identify trends with such low numbers, but feedback from those patents affected had been positive to date in terms of what is helpful for them as young people.

In response to a question from Mr Currie on whether the judgement handed down from the UK Supreme court on Scottish Parliament legislation linked to the European Convention on the Rights of the Child, would be relevant, Mr Hamilton confirmed that no impact was expected at a local level.

Ms Fallon asked if it would be possible for the Board to receive patient feedback in this area, and Mr Richards confirmed that the would take this action up through the Person Centred Improvement Service (PCIS) to establish the possibility of doing so. Further it was noted that Non–Executive Directors wished to be included in future training opportunities.

Actions – Mr Richards

Mr Moore summed up the positon of the Board as accepting the recommendations made in the paper, as well as thanking the team for all of their work in this area.

The Board:

1. Noted the content of The State Hospital Corporate Parenting Plan 2021 – 2023, supported its continued monitoring and review via the Child and Adult Protection Forum and supported the submission of this document to the Scottish Government Corporate Parenting Team.
2. Requested that the possibility of patient feedback being provided through the PCIS be

explored.
3. Requested that Non-Executive Directors be invited to training opportunities.

10 MEDICAL EDUCATION REPORT

A paper was received from the Medical Director (Paper No. 21/75) to give the Board a regular update on the progress made toward the General Medical Council standards for medical education which covered the period 1st August 2020 to 31st July 2021.

Professor Thomson presented this report to the Board summarising the key aspects of training for undergraduates and postgraduate doctors within TSH. She detailed the changes made in the provision of this due to the impacts of Covid-19, and how this had been managed, to ensure a high quality of training could be provided.

She also highlighted a key issue as being a growing trend for part-time working for trainee medics as of work to life balance and a potential for adjustment in attitudes to this following the pandemic. Ms Radage asked whether more could be done in this area through encouragement and support. Mr Currie widened this to take into account a possible recalibration of the approach to work in society and noted the huge investment made in medical training which may require long term thinking. Professor Thomson noted the value of the two-year foundation period completed. She provided assurance that TSH was working proactively to adapt to continue to attract and maintain medical staff within the wider national context.

Mr Moore summed up the Board's position that this was a comprehensive and reassuring report, which reflected well on the provision of medical education with TSH.

The Board:

1. Noted the content of the Medical Education report as a summary of key activity in this area.

11 MEDICAL APPRAISAL AND REVALIDATION ANNUAL REPORT 2020 / 2021

A paper was received from the Medical Director (Paper No. 21/76) to provide the Board with an update on the Medical Appraisal and Revalidation within TSH during 2020/21.

Professor Thomson noted the requirement for an annual report to be provided for the Board in this regard. She confirmed that there were well structured systems in place to monitor this including audits and monitoring of incident and complaints. There was no national audit during 2020/21 due to Covid-19, however, this report should provide the Board will reassurance that appraisals and revalidations were well managed and up to date within TSH. In answer to a question from Mr Moore on how patient feedback was sought, Professor Thomson confirmed that an opportunity was provided to patients to provide feedback questionnaire responses over a period of a month (rather than on a single instance of care as would be done in primary or acute care) and that this appeared to be working well.

Mr Moore noted the report on behalf of the Board and the good work in this key area.

The Board:

1. Noted the content of the Medical Appraisal and Revalidation Annual Report 2020/21.

12 QUALITY ASSURANCE AND QUALITY IMPROVEMENT

A paper was received from the Medical Director (Paper No. 21/77) to provide the Board with an update on the progress made towards quality assurance and improvement activities since the last

Board meeting in August 2021.

Ms Merson presented this paper to the Board the key areas of activity. She focussed on the key areas with Quality Improvement. Quality Assurance, Realistic Medicine and Evidence for Quality. This included the work on clinical audits and recent negative shifts noted on patient activity indicators. She highlighted the development work being progressed through the Quality Forum on its aims and objectives, as well as the use of QI in project work on the pre-admission needs assessment. Within Realistic Medicine she noted the appointment of a part-time Project Manager post to support this workstream.

Ms Fallon asked for an update on access to the GP service and also on Learning into Practice seminar sessions. Professor Thomson advised that the provision of GP services was being kept under review, with additional support being provided through the Nurse Practitioner as well as trainee doctors, However, she acknowledged that this was not as strong a provision as had been previously been experienced by patients, and therefore would continue to be closely monitored. She advised that the Learning into Practice seminars were a recently introduced practice and appeared positive to date. She suggested that feedback on this could return to the Board in due course, allowing the process to develop further.

Ms Fallon and Ms Radage asked for more information in respect of auditing on 'as required medication' and whether this was a wider issue of concern if the reason the medication was required was not being recorded on the medical Kardex. Professor Thomson advised that from the medical perspective, the reason for the medication was always known, and Mr Richards agreed that this would be recorded appropriately within the electronic patient system (RiO). However, this issue had been remitted to the Medicines Committee for review and recommendations for improvement.

Mr Moore asked how trends and learning from clinical audits was captured more generally, as well as trends or patterns from incident reporting. Ms Merson confirmed that the Operating Model Monitoring Group took oversight in terms of incident reporting. She noted that trend reporting should be included (on an exceptional basis) with respect to clinical audits as part of future reporting.

Action – Ms Merson

Mr Moore thanked Ms Merson for this report which the Board considered to be importance especially in terms of the opportunities for improvements.

The Board:

1. Noted the content the report and the breadth of work detailed within it.
2. Noted that trend reporting would be included within the clinical audit section, as appropriate.

13 CLINICAL FORUM

The Board received the agreed minutes (CF(M) 21/04) of the meeting of the TSH Clinical Forum which took place on 27 July 2021, and noted the content contained therein.

The Board:

1. Noted the minutes of the meeting of the Clinical Forum which took place on 27 July 2021.

14 ATTENDANCE PERFORMANCE REPORT

The Board received a paper from the Director of Workforce (Paper No. 21/78) outlining the high level position on staff attendance for the most recently reported period to 30 September 2021. Ms Davidson provided a summary of the report encapsulating sickness absence as well as absence due to Covid-19. She highlighted long term sickness absence as a continuing area of concern for TSH,

and provided assurance on the support provided to staff through their line managers who were in turn supported by dedicated Human Resources contacts. The Staff Governance Committee would review this area in detail at their next meeting.

Mr Moore noted this as a useful for the Board on the overall positon.

The Board:

1. Noted the content of the Attendance Performance Report.

15 FINANCE REPORT AS AT 30 SEPTEMBER 2020

A paper was submitted to the Board (Paper No. 21/79) by the Finance and eHealth Director, which presented the financial position to 30 September 2021.

Mr McNaught led Members through the report, highlighting the underspend position of £133k, and that year end forecasting was for a breakeven position. In terms of capital planning, he advised that the report indicated where monies was committed and would be spent in the remainder of the year, and that the budget would be fully utilised.

Ms Radage asked about costs pressures which could impact on the forecast breakeven position, including rising costs as continued use of overtime payments. Mr McNaught confirmed that although the rising costs of energy could be experienced, this was factored in with sufficient contingencies in place for the winter period. Mr McConnell asked about funding for "as if at work" and Mr McNaught confirmed that this was through the release of funds to the end of September. Further pressure going forward would necessitate the release of more funds.

Mr McConnell asked about the phasing of target savings, noting that more than half were still to be delivered in the last 6 months of the year. Mr McNaught advised that savings may not be achieved equally throughout the year, and it was to be expected that Quarters 3 and 4 would see a greater rate of savings being achieved. He also clarified that within TSH vacancies were not treated as recurring savings in accounting practice, though long term service changes may in some cases make this appropriate. Mr Currie picked up on this issue, and asked about the potential for vacancies not being deleted and counted as recurring savings or of delay in recruitment until after the financial yearend, and noted the need to ensure that such savings were real rather than delayed. Mr McNaught agreed noting the pressure TSH came under in having a high proportionate rate of staff costs as recurring spend compared to other NHS Boards. This made identifying non-staff related savings difficult for budget holders who continued to work well towards doing so. He agreed that appropriate vacancy management was essential.

In answer to a question on an overspend on eHealth project work, Mr McNaught explained that this was due to timing aspects and was not of a wider concern. Mr Currie asked whether availability of contractor generally was a risk, and Mr McNaught advised that this did not appear to be the case to date – some delays had been noted ion procurement (e.g. longer run in period for vehicle procurement) and the TSH Capital Group was keeping wider impacts under close review.

Mr Moore asked about costs related to e-rostering and Mr McNaught confirmed this was being led at a national level.

The Board:

1. Noted the content of the Finance Report to Month 6.

16 PERIMETER SECURITY AND ENHANCED INTERNAL SECURITY SYSTEMS PROJECT

A report was received from the Director of Security, Resilience and Estates (Paper No. 21/80) which

provided annual reporting in relation to the Perimeter Security and Enhanced Internal Security Systems Project. Mr Walker asked the Board to note the key aspects of the report including the small overspend projected, as well as revised timescales. This meant that the project work was expected to be completed by late April 2022, and the that this was due to the agile approach to design packages and the associated review required. All quality targets continued to be met, and the total spend to date was £8.7m.

The Board were content to note the content of this update, and that further updates would be required within a private session of the Board due to security information and commercial sensitivities involved.

The Board:

1. Noted the content of this report.

17 DIGITAL TRANSFORMATION UPDATE

A paper was submitted to the Board (Paper No. 21/81) by the Director of Finance and eHealth, which presented the requirements of the Board and the ongoing digital transformation agenda including an overview of activities taken forward by the eHealth Department.

Mr McNaught presented this papers and highlighted the upgrade to the electronic patient information system (RiO) which was an extensive piece of work, and would future proof the system. He also asked the Board to note the update on the Helpdesk, which showed the volume of calls being managed. He also noted the continuing importance of cyber security, and that TSH was fully up to date and had followed through on national alerts.

On behalf of the Board, Mr Moore thanked Mr McNaught for this update, and underlined the importance of resilience in the area of cyber security going forward.

The Board:

1. Noted the content of this report,

18 RISK MANAGEMENT ANNUAL REPORT 2020 / 2021

A paper was received (Paper No. 21/82) from the Director of Security, Resilience and Estates to provide a high-level summary of activity undertaken by the Risk Management Department during over period 1 April 2020 until 31 March 2021.

Mr Walker summarised the report for the Board, noting the change in departmental name and placement within the management structure. He also noted the appointment of a new Head of Risk and Resilience. He highlighted areas of developing good practice, embedding good risk practise across the organisation. This was clearly evidenced in the progress being made on actions coming from adverse incident reviews. He added that the department was also focusing on resilience planning and was undertaking review of incident command support in particular in the current year.

The Board welcomed this report as evidencing an area of positive development. In response to request for clarification, Mr Walker confirmed that TSH was not a Category 1 or 2 responder but comply with the majority of NSH Standards as good practice. He also advised that significant improvements had been made in liaison arrangements with Police Scotland.

The Board noted the timing of the Annual Report, and agreed this would be re-considered as part of the workplan for the coming year.

Action – Mr Walker/ Ms Smith

Mr Moore summed up the Board's positon as considering this to be a valuable report which evidenced continuing improvement in this area, and thanked the team for their work.

The Board:

1. Noted the content of this report.
2. Agreed the timing of the report should be reviewed.

19 COMPLAINTS ANNUAL REPORT 2020 / 2021

A paper was received form the Board Secretary (Paper No. 21/83) to provide reporting to the Board on activity and performance within complaints handling for the year 1 April 2020 to 31 March 2021.

Ms Smith provided a summary of reporting to the Board, introducing this as a new format of report for the Board following a change in management structure this year. She highlighted that TSH had maintained a full complaints service throughout the pandemic, with the Complaints Officer able to continue to meet with patients subject to Covid-19 restrictions. Response times and key performance indicators, as part of the Model Complaints Handling Procedure, had continued to be met. There had also been review of qualitative measures including decision-making on outcomes for each complaint. Ms Smith underlined the importance role the process plays for the organisation to acknowledge when there have been challenges in service delivery, and taking learning. She noted the changes in governance arrangements as well as ongoing service development within the department.

The Board welcomed the report and provided a view that this new format of reporting was helpful and informative. Members asked for clarification on the dip seen in receipt of patient feedback forms, and Ms Smith acknowledged that this could be a difficult area with a small cohort of patients who may raise more than one concern throughout their admission and not necessarily be inclined to complete multiple feedback forms. However, she would liaise with the Complaints Officer to think creatively about how this could be developed to further encourage patient feedback. The Patient Partnership Group could be central to this.

Members also asked about whether there were specific benchmarks for the number of complaints resolved at stage one of the process i.e. before escalating to stage two. Ms Smith clarified that there were no specific targets but that every effort was made to resolve concerns as quickly and directly as possible, and that the hospital was evidencing a strong ability to do so through the efforts of the Complaints Officer as well as front line staff. In response to a question about progressing training, Ms Smith noted the challenges in the last quarter of doing so due to Covid-19 restrictions as well as staffing capacity but that this was a key area of focus going forward. Mr Moore noted the positive uptake of eLearning by staff overall during this period.

Mr Moore thanked Ms Smith for the report and confirmed that the Board were content with its format for annual reporting, and that it had been helpful to receive assurance on the work progressed on improvement measures. On behalf of the Board, he noted thanks to the team for their work in this regard.

The Board:

1. Noted the content of the Complaints Annual Report 2020/21.

20 AUDIT COMMITTEE

The Board received the approved minutes of the meetings of the Audit Committee that took place on 17 June (A(M)21/03) and 22 July 2021 (A(M)21/04).

As chair of the Audit Committee, Mr McConnell also provided a verbal update on the meeting that took place on 6 October, which had been focussed on internal and external audit reporting, risk and resilience as well as self–assessment by the Audit Committee. The approved minutes would be submitted to the Board in due course.

The Board:

1. Noted the approved minutes of the Audit committee meeting from 17 June and 22 July 2021.

2. Noted the update from the meeting on 6 October 2021.

21 CORPORATE RISK REGISTER

The Board received a paper (Paper No. 21/84) from the Director of Security, Resilience and Estates, which provided an overview of the medium, high and very high risks featuring on the Corporate Risk Register, and to provide assurance that these were being addressed appropriately.

Mr Walker confirmed that there had been no risks added or changes since the date of the last Board meeting, and asked the Board to note the work progressing on the re-alignment of governance structures underpinning oversight of the risk register.

Mr Moore thanked Mr Walker for reporting, and noted the importance for the Board to continue to give careful consideration to the risk management framework and how this reporting meets the Board's need for assurance in this area. He noted the Board's agreement that no further amendment was required to the register as a result of matters considered at this meeting.

The Board:

1. Noted the content of this report.
2. Agreed that no further addition or amendment was required to the register as a result of this meeting.

22 BOARD AND COMMITTEE SCHEDULE 2022

A paper was received (Paper No. 21/85) to outline the proposed schedule of meetings during 2021. Ms Smith noted that the schedule had previously been circulated to members and was now being submitted for final agreement. Once amendment was required to the date of the Staff Governance Committee in August 2022. And would be corrected prior to the schedule being published.

The Board:

1. Agreed the schedule of meetings for 2022.

23 ANY OTHER BUSINESS

No other business was raised.

24 DATE AND TIME OF NEXT MEETING

The next meeting would take place on Thursday 23 December 2021, by way of MS Teams.

The meeting ended at 1300 hours.

ADOPTED BY THE BOARD

CHAIR _____

(Signed Mr Brian Moore)

DATE _____

THE STATE HOSPITALS BOARD FOR SCOTLAND
ROLLING ACTION LIST

ACTION NO	MEETING DATE	ITEM	ACTION POINT	LEAD	TIMESCALE	STATUS
1	February 2021/April 2021	Resilience Report – Covid-19 (Item 7a)	Provide benchmarking comparison to other organisations on use of virtual visiting	R McNaught/ D Walker	Re – adjusted to February 2022	**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.** **Update – Work progressing but subject to delay and fuller reporting to February Board 2022**
2	August 2021	Covid Resilience Report (Item 7a)	To progress work on link between performance metrics and the governance structure e.g. how do individual metrics get tracked.	M Merson/ M Smith	Re-adjusted to February 2022	**Work in progress as part of performance metrics / active governance and update to be brought back to board.** **Update – Active Governance session scheduled for Jan 2022**

3	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.** **Update: Board reviewed in detail and considered governance arrangements for 2022. Added to Board Workplan in this meeting. CLOSE.**
4	August 2021	Corporate Risk Register(Item 22)	To review the oversight committee for each risk –clarify executive /board oversight.	D Walker	December 2021	**On October Agenda as part of reporting. Report reviewed and suggestions made, new format of reporting is included in December meeting.**
5	October 2021	Covid Resilience Report (Item 7a)	Provide update on digital inclusion/care	R McNaught	December 2021	**On Agenda as part of eHealth Annual reporting**
6	October 2021	CEO Report	Development of target operating model for workforce – to remit to Staff Governance Committee and then reporting back to Board	L Davidson	Immediate	**SGC reporting/workplan in place, and workforce reporting in line with national guidance is included in Board Workplan . CLOSE**
7	October 2021	Corporate Parenting Plan (Item 9)	Route patient feedback through PCIS in this area, for future reporting. Also Non- executive to be involved in future training opportunities	M Richards	Immediate	**PCIS to include as feedback and agreed that future planned training will extend to NXDs. CLOSE.**

8	October 2021	QA and QI (Item 12)	Request that trend reporting on clinical audits be included in future reporting.	M Merson	February 2022	**Review as part of reporting in QA and QI/ clinical model board reports.**
9	October 2021	Risk Annual Report	Review timing of annual reporting as part of workplan.	D Walker/ M Smith	December 2021	**Board workplan adjusted to bring this to June meetings. CLOSE.**

Updated – 13.12.21 – M Smith

Author:
Margaret Smith
Board Secretary
01555 842012

Paper No. 21/90

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	23 December 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). This is through 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 Corporate Risk Register will be presented to the Board at this meeting, and the Risk for Covid-19 has been re-assessed as Very High, given the presentation and potential impact of the Omicron variant.

2 BACKGROUND

This report will provide the Board with a detailed update on the framework through which TSH has continued to manage its response to Covid-19, since the date of the last Board meeting.

2.1 Senior Leadership and Management Structure

Management Structure:
The Incident Command Structure can be stood up urgently should this be required. On 9 December, a Level 2 Incident Command Structure was stood up, chaired by the Chief Executive.

A Level 2 Command is defined as an incident of a more serious nature or with potential to escalate which may require an Incident Command structure and significant resources to contain the incident and co-ordinate the running of the rest of the hospital. This action was taken in view of the global developments around the Omicron variant, and the impacts this

may have on service delivery for TSH. The terms of reference for Incident Command also extend to include the impacts on service delivery due to staffing capacity within nursing, and also the increased risk presented by the final phase of the security upgrade project during a period of winter pressures. The combination of these risk factors for TSH can be led cohesively through Incident Command.

Incident Command will receive a range of reporting including modelling and surveillance stat at a local, regional and national level. This includes links to NHS Lanarkshire's Horizon Scanning Group as well as the Lanarkshire Resilience Partnership and the NHS Scotland Weekly Systems Pressure Group. In addition, national guidance will be reviewed to ensure an appropriate TSH response, and to ensure alignment with NHS Scotland strategy.

Incident Command is meeting weekly to provide leadership within its terms of reference, whilst the business as usual structure of the Corporate Management Team (CMT), the Organisational Management Team and the Hospital Management Team continue to operate. This will be kept under regular review, and the Board will be advised of any significant changes.

At its last meeting, the Board received a detailed update on the continuing review of the revised management structure, which was brought into being in December 2020, including formal review by the CMT. Development work continues to be progressed around the Hospital Management Team in particular, to help support and build upon the role this group plays within the hospital, and its link to hub management and clinical leadership structures.

Dedicated support for the response to Covid-19 is 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 small 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).

Remobilisation Planning:

The updated Remobilisation Plan for the final two quarters of the current financial year was submitted to Scottish Government by the deadline of 30 September 2021, and confirmation has now been received that the plan can be published **(Appendix A).** TSH will develop a forward plan which will be informed by Scottish Government guidance for the development and cohesion of NHS Board Plans. Planning is in place for this to be submitted towards the end of Quarter 1 in 2022, aligned to national planning. The plan be presented in the format of a one-year delivery plan with key priorities and deliverables identified and progress again these will be reported. There will also be a longer term forward plan focused on recovery which will provide a narrative on a three-year forward look.

It is recognised that this is a dynamic landscape, and that the emerging strategic direction of wider forensic mental health services. Therefore, TSH delivery planning will reflect the outcomes of these strategic developments.

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

Delivery of care within TSH has continued to be managed through the Interim Clinical and Support Services Operational Policy. 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 regularly, and this will be routed through Incident Command.

3.2 Infection Control Committee

The Infection Control Committee meets monthly with enhanced oversight for the management of Covid -19 within TSH. This includes detailed review of National Guidance on infection control requirements for any impact on TSH. The programme of Covid-19 audit work is continuing as part of the wider programme of infection control audit. Infection Control support continues to be provided to all staff, especially around the importance of following guidance and appropriate use of PPE. Escalation of any concerns will be routed through Incident Command.

Additional support continues to be provided by the Infection Control team in NHS Lanarkshire.

3.3 Covid-19 Incidence

There are clear guidelines in place for incidence of Covid-19 in both the patient and staff cohorts following national guidance and including isolation, testing and contact tracing.

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	June	July	August	Sept	Oct	Nov
Total Tests	19	17	25	81	62	153
Asymptomatic tests	17	13	2	73	59	149
Positive results	0	0	2	4	3	6
Negative results	19	17	23	77	59	147

Table 1: Patient Tests and Results June – Nov 2021

Table 2 below provides the updated position on staff testing and incidence of Covid-19, over the past three-month period. This provides the total number of PCR tests reported for staff members, in numerical and percentage terms across each month as well as an indicator of the positivity rate as compared to the whole staff group numbers.

	Total	Positive results	Negative results	% positive tests (of all tests)	% positive rate (of staff *wte n650*)
September	103	17	86	16.5%	0.03%
October	72	18	54	25%	0.03%
November	77	12	65	15.6%	0.02%

Table 2: Staff PCR testing and results

3.4 Response to Outbreaks

There have been two small outbreaks of Covid19 within the hospital since the date of the last Board meeting. Each of these has been managed by of Incident Management Teams (IMTs), with membership including senior colleagues from Scottish Government Incident Management, Public Health, the Infection Control Consultant from NHS Lanarkshire as well as from Test and Protect.

The first incident opened on 8 November, with four patients in Lewis 2 and Mull 2 testing positive for Covid-19, as well as one staff member. The IMT hypothesis was community transmission within this area, although the link of the staff member to this outbreak was not confirmed. The outbreak was managed through means of isolation, and contact tracing and testing and no further cases were found to be linked. The incident was formally closed on 22 November.

A further IMT was convened on 19 November, following a patient from Iona 2/Arran 3 who had attended acute hospital care (non-covid related) subsequently testing positive for Covid-19. Another patient within Iona 2/Arran 3 wards also then tested positive on 27 November. However, the IMT hypothesis was that these two cases were not linked. IMT led management through appropriate isolation, contact tracing and testing and no further cases were found. This incident was formally closed on 11 December 2021.

3.5 Covid-19 Vaccination Programme

TSH has continued to deliver its 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 two doses of the vaccine, with an uptake of 88%. Additionally, 274 members of staff from this cohort have now received the booster vaccine and this represents 49% of staff who received the first two doses onsite. At the same time, staff will have been able to book their own booster through the community led programmes. To encourage uptake further, Infection Control have asked for all staff to note their interest in receiving the booster within TSH. There is a complication in this as the vaccine is supplied in packs of 90 bringing difficulty in identifying a staff cohort large enough to prevent potential wastage. Infection Control have secured a smaller supply pack from NHS Lanarkshire so that a clinic could take place to meet staff needs. A staff vaccination clinic was held on 16 December, with 40 staff receiving their COVID booster.

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 vaccination, depending on their individual stage within the vaccination cycle and uptake remains high.

Patients within the clinically vulnerable cohort were vaccinated on 29 October, with nine patients receiving the booster on this day. Clinics then took place at the end of November to roll out the booster to a further 62 eligible patients. Given the change of national guidance, patients can now have their booster after three months with a further clinic is taking place on 17 December to administer the booster to 21 more patients. The remaining patients will be offered the booster when they become eligible depending on when they received their second dose. Uptake will be monitored and as previously, patients will be supported and advised on the importance of vaccination.

3.6 Test and Protect

All staff continue to be encouraged to self-test by Lateral Flow Device (LFD) is on a voluntary basis, and to register their test results. However, reporting rates remain low across NHS Scotland with TSH reporting a slightly increased rate of 11% on average compared to a national rate of 13% (reported as a percentage of the expected overall number of tests).

The importance of regular testing by LFD is a key focus of national guidelines, especially given the presentation of a new variant (Omicron) and any change to national guidance on the frequency of testing.

Work is therefore continuing through internal communications as well as in partnership with staff side colleagues to continue to encourage staff to report LFD testing.

All contractor coming on site continue to be required to 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

The CMT has 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 has recognised 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.

Following advice from NHS Lanarkshire to establish what medical care is now considered to be both safe and feasible within a TSH medical ward, the CMT took the view that it would not be necessary to take any further steps to stand up the medical ward within TSH at this point, although this will be kept under review. If this was required in the future, it is expected to involve the delivery of low flow oxygen, or palliative care.

3.8 Personal Protective Equipment

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

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 focused on the transfer of those patients assessed as ready to move to another setting as soon as possible with focus on the number of patients considered ready to move to medium secure facilities within NHS Greater Glasgow and Clyde, as well as those for whom a prison setting would be appropriate.

A weekly transfer review meeting has been set up, linking TSH with medium secure units, as part of the Forensic Network Capacity Plan. There continues to be clear clinical governance

arrangements in place for patient admissions, and a waiting list has been set up. Work has also been progressed on contingency planning within TSH to optimise the bed space available, including possible use of the vacant ward in Mull.

The following table outlines the high level position from 1 October to 30 November 2021.

	MMI	**LD**	**Total**
Bed Complement	128	12	140
Staffed Beds	108	12	120
Admissions	2	0	2
Discharges / Transfers	5	0	5
Average Bed Occupancy: Available beds/All beds			97% **/** 82.9%

Table 3: Patient flow 1 October to 30 November 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. This ensures the best approach to support visiting within infection control guidance.

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. TSH will continue to follow national guidance on hospital visiting, to ensure compliance with infection control guidelines. This is being actively reviewed by the Infection Control Committee at its meeting on 16 December 2021.

The CMT commissioned a clinically led review on 17 August 2021, to consider the optimal visiting model, and this was formally reported to the CMT on 15 December. The recommended way forward agreed was to support the continuation of visiting within the Family Centre, to meet the needs of patients and carers and to respond to the positive feedback on the current model.

However, the review also supported the need to take a risk informed approach, identifying key structural works to the existing Family Centre which would be needed to implement this approach in the long term. Therefore, the CMT commissioned further implementation planning for this model, including the capital cost, and requested that this be reported by February 2022.

The existing model will continue in the meantime, subject to any relevant national restrictions to hospital visiting.

Virtual Visiting

Virtual visits are taking place through video-conferencing and this is a valued means of keeping in contact for many patients and carers.

Development work to review other means of supporting virtual means of visiting including alternative platforms is continuing but has been delayed due to capacity and work pressures as well as the complexity of information governance in this regard. This is nearing completion to allow a pilot to progress. This is a key area of focus in early 2022, and the Board will receive reporting in this respect at its next meeting.

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 have continued to take forward the recruitment process for all confirmed positions with appointments made across a range of disciplines. There are currently 28 posts actively moving through the recruitment process from the following departments: Nursing, eHealth, Medical, Psychology, Security, Nursing practice development, Human Resources, Housekeeping, Finance and Executive level.

Since the date of the last Board meeting, recruitment activity has concluded for posts within Ward Based Nursing, Skye Centre, Security, Therapeutics, Psychology and Catering.

There continues to be key focus on recruitment to nursing posts, and the promotion of TSH as an employer, given the national challenges in this area.

3.11.4 Staff Wellbeing

The Staff Wellbeing Centre has been used every day with staff dropping in for tea breaks and lunch breaks as well as making use of massage equipment. TSH Volunteers have also been using the space every Wednesday for lunch and relaxation. It is recognised that changing national guidelines will now impact this, and that use of the centre will continue to be managed in line with infection control guidance.

A December 'Wellbeing Week' has taken place (commencing on 13 December) offering staff an opportunity to engage in relaxation sessions (subject to physical distancing) as well as individual health checks and physiotherapy taster sessions. There are health promotion information stands in the wellbeing centre around; alcohol/drug awareness, sexual health, women's and men's health advice, mental health, back care awareness and stress management. This event has been well publicised through staff bulletins.

TSH Wellbeing Advisors continue to meet with and engage staff across the hospital to discuss wellbeing support. This includes all areas in the hospital including ward staff who may

otherwise find it difficult to aces the centres due to shift working patterns. An appointment has now been made to the Healthcare Pastoral Support post, and the post holder is due to commence early in the new year. This post is through a Service Level agreement with NHS Lanarkshire.

Work is progressing to engage staff in the further development of the Wellbeing Strategy, through department business meetings as well as the HR and Wellbeing Group. The Healthy Working Lives Group met in December to discuss embedding wellbeing strategy and strengthening the membership for the group.

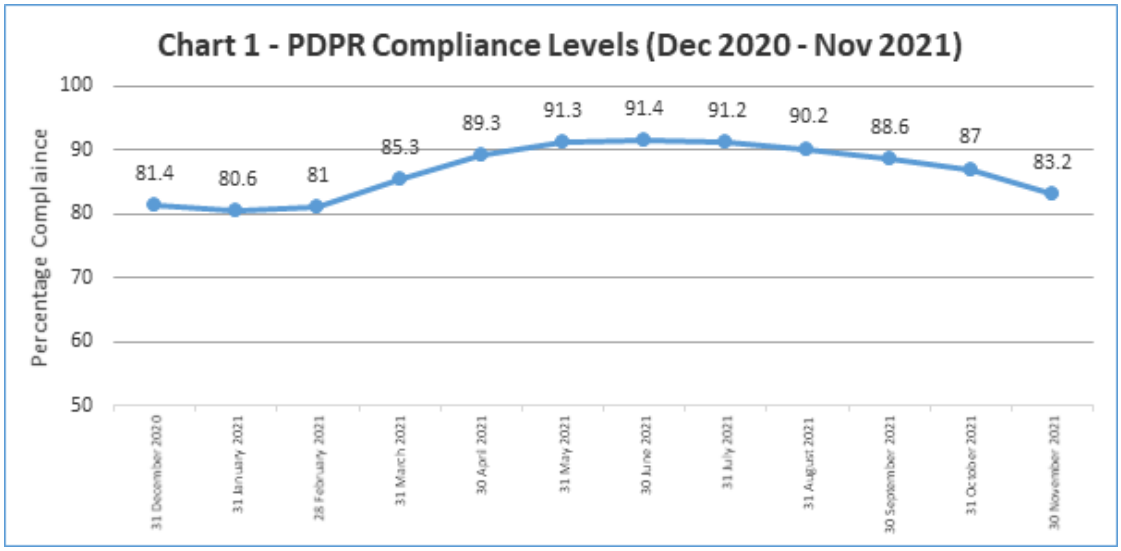
Part of the Wellbeing workstream is focus in how this can be supported through helping others – once again TSH staff have shown their generosity through the donation of over 100 gift packages to the Salvation Army, at a time of year that many families can find difficult.

3.11.5 Personal Development Planning and Review (PDPR) compliance

As at 30 November 2021:

- The total number of current (i.e. live) reviews was 500 (83.2%).
- A total of 82 staff (13.6%) had an out-of-date PDPR (i.e. the annual review meeting is overdue).
- A further 19 staff (3.2%) 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 December 2020 to November 2021.



As indicated in Chart 1, PDPR compliance levels have shown a slight downward trajectory from July 2021. Staff absence and associated staffing resource pressures have been significant over the past 3-4 months and this has been reported by managers as a key contributory factor in this reduction in overall 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. During this period there has been focus on ensuring regular, clear communications have been issued to all staff. These have covered the importance of infection control and prevention measures, as well as the management of the Covid-19 outbreaks within the hospital. Regular bulletins are issued to staff from Incident Command.

There has also been an opportunity to highlight the work of the Wellbeing Centre, as well as the Staff Excellence Awards which took place on a virtual platform on 30 November 2021.

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.

Oct 2021 – Mar 2022

The State Hospitals Board for Scotland

REMOBILISATION PLAN VERSION 4

Table of Contents

1. Introduction

This plan describes The State Hospitals Board for Scotland (TSH) approach to remobilisation for the period October 2021 to March 2022. It provides a 6-month update on progress from plans outlined in the Remobilisation Plan Version 3 (RMP3) which described the full year plans for 2021/22.

All aspects of the Boards remobilisation are aligned and reflective of the key principles outlined in The Framework for NHS Scotland: 'Re-mobilise, Recover, Redesign.' In addition to treating the mental health needs of patients our priorities for 2021/22 are:

- Address the physical health care needs of patients
- Promote and support staff wellbeing
- Develop a culture of continuous quality improvement
- Implement changes to the clinical model
- Work with key partners including Scottish Government and NHS Boards, as part of an overall system approach to improve the bed capacity for across the forensic mental health estate
- Improve digital capability and resilience

The core clinical function of TSH 'providing high secure care and treatment' has remained unchanged throughout the Covid 19 pandemic. Any patient who required admission for high security mental health care and treatment has been accepted and admitted. Referral routes from the justiciary, prisons and other NHS providers have been maintained.

Throughout the pandemic, the major change in TSH related to how care and treatment was delivered, supported by a safe clinical environment, where infection prevention and control has been central to all decision making.

2. Pandemic Response

2.1. Infection Prevention and Control

The delivery of care throughout the pandemic has been managed through the TSH Route Map and the Interim Clinical and Support Services Operational Policy (ICOP). The aim of ICOP has been to affect a phased remobilisation to support rehabilitative and therapeutic activity for TSH patients, whilst planning service delivery in line with the Scottish Government Route Map.

At 15 June 2021, there had been 22 versions of the ICOP reflecting the changing nature of restrictions and dynamic response to the pandemic. Version 22 supported the re-introduction of patient mixing across the site as well as the reinstatement of rehabilitative and compassionate outings.

Throughout the pandemic, focused leadership for infection prevention and control has been at the centre of the approach taken at TSH. External support has been provided in collaboration with the Public Health team in NHS Lanarkshire. TSH continues to adhere to national guidance on infection prevention and control. To support compliance a programme of Covid 19 audit work is conducted as part of the wider programme of infection control audit. TSH has recruited to a new post of Clinical QI Facilitator to add resilience for the organisation in this specific area.

Across the timeframe of the pandemic, incidence of Covid 19 in the TSH patient population has been relatively low. Robust plans are in place should any patient be symptomatic and require testing. TSH practice follows national guidance in respect of contacts who have been double vaccinated. TSH has six clinical operating models in place based on the prevalence of infection in the patient population. These have been successfully implemented across TSH throughout the duration of the pandemic and have proven successful.

2.2. TSH Living with Covid 19

The requirement to manage the risk posed to TSH from Covid 19 has been transferred to the Corporate Management Team (CMT). The following integration into business as usual practice was agreed from September 2021:

- The Scientific and Technical Advisory Group (STAG) will stand down replaced with Covid 19 related intelligence being assessed through the refreshed Terms of Reference of the Infection Control Committee.

- CMT will receive an exception report from the Infection Control Committee to actively monitor compliance and respond to Covid related issues.

- The process for outbreak management is aligned to the national model of the PAG (Problem Assessment Group) and the IMT (Incident Management Team) with external support from national specialist advice.

- TSH will participate in the Horizon Scanning Group led by NHS Lanarkshire to assess and advise on emerging pandemic intelligence locally and nationally.

- The CMT will receive local monitoring reports and surveillance intelligence as well as national modelling advice at each meeting.

- The dedicated Covid 19 support team is in abeyance with support being managed through existing structures. The Covid 19 support team and command structure can be stood up urgently, should this be required. The CMT have an additional post in place to coordinate any resilience response that may be required.

2.3. Covid 19 Vaccination Programme

TSH has undertaken a programme of vaccination for both patients and staff as part of the national roll out.

As of 31 July 2021, all eligible staff had been offered the vaccine with 88% of staff in this cohort having been fully vaccinated. This figure does not include staff who have been vaccinated by their local NHS Board through the national vaccination programme.

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

A group was established to plan for the roll out of Covid 19 booster and flu vaccinations for patients and staff. A delivery plan is in place to offer Covid 19 booster and flu vaccinations to front line staff and patients, starting on 1 October 2021. Staff have also been signposted to community vaccination clinics, which are accessible via NHS Inform.

2.4. Test and Protect

In line with all other NHS Boards, TSH began a programme to coordinate implementation of Lateral Flow Devise (LFD) testing at a local level. The programme commenced in December 2020. This was initially focussed on patient-facing healthcare workers, but has now been extended to all staff. This self-testing is on a voluntary basis, and all staff are encouraged to participate and register their test results on a twice weekly basis. Work continues in partnership to encourage staff to upload the results of their LFD tests.

TSH requires all contractors coming on site to undertake LFD testing. Auditing and reporting is in place. No issues have been noted with uptake and management of this control measure. All relatives

and visitors are encouraged to undertake a LFD test prior to their visit to TSH. Testing facilities are available for visitors if required.

3. Key Risks and Mitigations

There remains challenges and risks in the following areas:

3.1. Covid 19 infection outbreaks

The risk of Covid 19 infection remains high. However, the impact of the infection on staff and patient health has been mitigated to a certain extent by the roll out of the vaccination programme, as noted in section 2.3. Adaptability and flexibility will continue across the organisation in order to respond to any specific outbreak, to ensure safety and continuity of service.

Consideration is being given to re-opening the medical ward within TSH to provide care for patients should they become physically unwell. This will be undertaken in collaboration with NHS Lanarkshire Emergency Department with pre-agreed escalation points for medical intervention. Bed availability in NHS Lanarkshire will continue to be monitored to assess demand and capacity risks.

3.2. Workforce

Like all public sector organisations, there has been periods of increased staff absence associated with isolation and Covid 19 infection. Business continuity measures have been implemented in relation to the delivery of clinical service provision during reduced staffing availability. These have been tested on several occasions and will continue to be implemented should circumstances determine.

Staff recruitment activities continue in order to mitigate voids created by staff retirals. Seasonal illness continues to be a risk; however, the flu vaccination rollout is planned for all staff and patients as part of TSH annual cycle. Furthermore, work will continue to explore how enhanced resilience can be achieved within the highly specialist mental health workforce in TSH.

3.3. Management of Violence and Aggression

The management of violence and aggression continues to be a risk in TSH. This is mitigated by a range of specialist care and treatment approaches. The Care Programme Approach (CPA) reviews key clinical metrics which are monitored daily to understand how these risks are being managed and mitigated. Patients displaying escalating episodes of violent behaviour are specifically reviewed at key trigger points.

3.4. Obesity

Patient physical health remains a key clinical priority, obesity is recognised as a high risk to patient's overall health status. The Board has recently agreed a revised action plan to support healthier lifestyle choices for patients. The refreshed Supporting Healthy Choices strategy will be introduced over the next six months. A recruitment process is underway for a dedicated Programme Manager to provide focused resource and improvement for this priority area of work.

3.5. Finance

There is a risk in relation to the year-end revenue position dependant on the ongoing Covid 19 revenue funding. Funding has been received for quarters 1 and 2 – however there is no confirmation at this stage that this will continue into quarters 3 and 4. Further detail is provided under section 15 on Finance.

3.6. Clinical Model

The implementation of the Clinical Model remains at risk due to the average higher number of patients which is greater than at any other point in the last 5 years. Work is underway in collaboration with the Forensic Network and NHS Boards to find innovative solutions in the short term to alleviate bed pressures across the forensic estate.

4. National Opportunities

The Programme for Government 2021-22 was published in September 2021. This outlined that the Scottish Government will publish a formal response to the Independent Review into the Delivery of Forensic Mental Health Services later this year.

TSH together with other NHS Boards will continue with their existing plans for Forensic Mental Health Services until the policy position is determined. In the meantime, TSH will work with the Forensic Network in scoping solutions associated with improving bed flow and capacity across the NHS Scotland estate.

5. Collaboration with wider organisations

TSH continues to work collaboratively across the wider forensic system, and with NHS Scotland Boards, Scottish Government and Public Sector. Key areas of work include:

- Input to the National Secure Adolescent inpatient pathway
- Development of the use of digital technology, including extending use to enable access within justiciary services
- Working with HMP Perth, as part of the Scottish Prison Service, to explore care and treatment pathways for a small number of highly complex personality disordered prisoners
- TSH continues to collaborate with the three high secure hospital in NHS England
- TSH will continue with its work in the Global Citizenship Programme, collaborating with colleagues in Pakistan on models for forensic mental health care
- Continued participation in the Scottish Patient Safety Programme and learning from adverse events with Healthcare Improvement Scotland

6. Planning Assumptions

6.1. Staffing Assumptions:

The plan for the remaining 6 months of the year assumes that staffing levels are consistent, and there is no major business disruption due to additional pandemic surges. Should there be a pandemic surge, the organisation will revert to incident command procedures to manage the emerging circumstances.

6.2. Sustainability and Environmental Management:

TSH has agreed to establish a Sustainability Management Group (SMG). This will ensure an integrated approach to sustainable development, harmonising environmental, social, and economic issues, and embed sustainability best practice within TSH. In addition, the Scottish Government has mandatory requirements for climate change reporting, biodiversity reporting, to which all public bodies (including NHS Boards) must adhere.

COP 26

Whilst there are significant planning scenarios underway for the COP 26 Conference, TSH is not a level 1 responder for this event. The assumption therefore is that there should be no associated consequence on the admission profile at TSH.

6.3. Patient Flow

TSH has consistently experienced higher numbers of patients since the onset of Covid -19 pandemic. The Mental Directorate has commissioned the Forensic Network to advise Scottish Government of possible actions to free up beds across the forensic estate ensuring patients receive treatment in the correct level of security related to their risk profile.

TSH continues to be linked with this work whilst the key focus is on medium and low security care. This includes admission to, and transfer between, secure mental health services, suspension of detention and preparation for moving patients into the community.

TSH is working to support the Forensic Network to develop a Draft Delivery Plan. This will be submitted by the Forensic Network to Scottish Government by 28 September 2021.

7. Winter Planning

The clinical function of TSH remained constant throughout the year, admissions and discharges tend not to show seasonal variation and are not affected by normal NHS winter demand pressures. In line with previous years and in agreement with Scottish Government, TSH has not completed a winter planning checklist. Winter planning in TSH reflects the specific organisational issues that can be experienced. Areas of challenge can be:

Staff attendance during severe weather and other resilience planning
A business continuity plan is in place to mitigate the effect of reduced staffing, and other plans exist to maintain essential service, utilities, and the supply chain. These plans are regularly reviewed and tested. TSH is aligned with the Lanarkshire Resilience Partnership (LRP).

Staff absence
Staff absence at TSH is monitored daily. There is a safety huddle in place to review service delivery and any onsite challenges. Decision making is escalated to CMT if pre-determined trigger points are reached in relation to loss of staff. There is a business contingency plan for mass loss of staff. This determines core business functions for the organisation if such an event is experienced.

Annual flu vaccination
A hospital wide Winter Flu and Covid 19 vaccination programme will take place across the hospital in line with national guidance. A pandemic influenza plan exists and is regularly reviewed.

Norovirus or Viral Infection
A policy on the “Management of Patients with Loose Stools” is in place and is regularly reviewed by the Infection Control Committee (ICC). The frequency of the ICC can be increased depending on any infection outbreak, at a minimum it meets monthly.

8. Recovery and Transformation

The Scottish Government published the NHS Recovery Plan 2021- 2026 in August 2021. This plan outlines the intention of Scottish Government to deliver sustainable recovery through a series of headline ambitions and actions including care programmes. Although TSH does not directly interface with many of the clinical areas laid out in the Recovery Plan. It does recognise the ambitions and aligns with the principles of focus on the entire system, ensuring quality and patient centred care, sustainability, valuing and supporting the workforce and reducing inequalities.

TSH Directors and the Board will continue to interact with the developments laid out in the Mental Health Transition and Recovery Plan 2020 through attendance and participation in national groups. They will continue to ensure alignment of organisational strategy with the principles of co-design, holistic service design and delivery which puts the needs and rights of those who use our services at the heart of our decision making.

8.1. Delivery Plan Progress Report Template

Appendix 1: The Delivery Plan Progress Report Template details the milestones, targets and deliverables outlined from TSH RMP3. The appendix details the progress made in the first 6 months of the year against those commitments. These were specifically:

- Digital Transformation
- Physical Activity to Improve Physical health
- Organisational and Clinical Effectiveness
- Staff Health and Wellbeing
- Building a Personalised Approach to Care
- Safety and Security

8.2. Recovery and Transformation specific to TSH

Key strategic areas of development include:

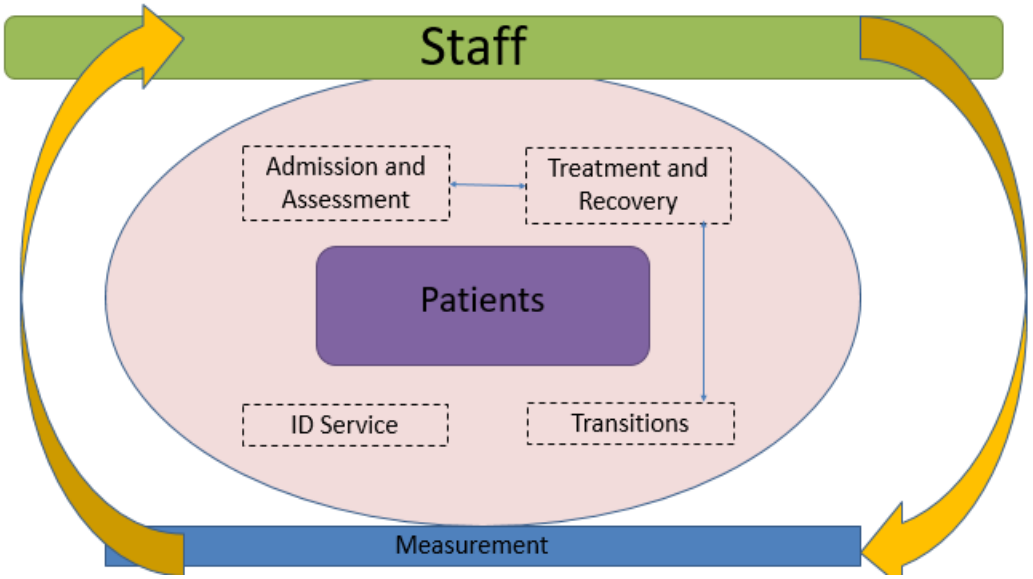
- Clinical Model and activity pathway redesign
- Digital Inclusion
- Staff Health and Wellbeing
- Performance Management and Continuous Improvement

9. Clinical Model and activity pathway redesign

The Clinical Model aim is to achieve a more focused recovery journey through TSH for patients and a safer working environment for staff.

The average length of stay for a patient in TSH is 6 years. Therefore, it is vital that patients experience a sense of progression and achievement through their clinical journey from admission to discharge. This will be achieved by changing the function of wards into Admission and Assessment, Treatment and Recovery and Transitions for major mental illness patients, together with 2 Intellectual Disability wards.

Engagement work has recommenced, and initial mapping has been carried out to check model fidelity. This is a restart of previously paused work where the evidence and intention were approved by the Board. The diagram below aims to have patients central to the core clinical function of the organisation.



The activity pathway redesign is integral to supporting all patients at each stage of their recovery journey as part of the new model.

Using Quality Improvement approaches and methods, TSH have identified barriers to change, mapped processes to understand patient and staff experience of the current systems and will design tests of change to develop innovative approaches and solutions to the activity pathway design.

Further work is underway to address the synergy and relationship between the clinical model and activity pathways to support patient progression and their physical health needs.

10. Digital Inclusion

The Scottish Government has set out a Digital Inclusion Strategy for all its citizens, and this is underpinned by a Digital Participation Charter. TSH is committed to ensuring its patients' needs are supported in this.

10.1. Virtual Platforms:

Virtual platforms are presently used for a range of interventions including virtual visiting, physical health interventions and clinical groups. A digital process has been successfully established with the Parole Board for Scotland.

The video conferencing facility is presently available for the provision of clinical groups with patients in attendance. To continue with our expansion of this digital innovation, 5 Polycom units and associated equipment has been purchased for each Multifunction zone and the Vocational Activity Suite in the Skye Centre, this enables access for all patients across the site. Patients, families and carers have welcomed this innovation in the use of technology at TSH.

The use of Microsoft Teams as a platform for the provision of patient groups, is still being considered and a local DPIA is being progressed. A national Data Protection Impact Assessment (DPIA) is awaited for the use of this platform for clinical groups.

10.2. Tableau:

A Quality Improvement project is underway to investigate how TSH can increase Tableau use. Business Tableau is a digital interface that enables the presentation of a range of real time data. The overall aim of this project is to increase the number of staff using the system and their confidence in using digital technologies. There are currently 8 dashboards which are live on the system, 5 under development and 2 project proposals accepted for future scoping and development.

10.3. Near Me

The Near Me platform is used widely across the NHS and within TSH for the delivery of physical health consultations and clinical interventions. This platform is a suitable option for the delivery of clinical groups due to the controls and security measures that are already in place. The present functionality of this platform however is considered to be limited for what our clinicians would like to achieve, developments are being progressed with an expected release date for the upgrades in October 2021.

10.4. Technology and Communications Short Life Working Group:

Scottish Government requested that a Communications and Technology Short Life Working Group (SLWG) was convened in Dec 2020 to reconsider work carried out in 2018. The SLWG aimed to balance support for patients to maintain social and family ties whilst maintaining security, safety, and privacy. The group reconsidered the original piece of work, revisited the themes contained within the report and refreshed the recommendations for use in forensic mental health settings in Scotland. Approval is awaited from Scottish Government Mental Health Directorate.

In addition to the work cited above Appendix 1, The Delivery Plan Progress Report Template, details additional digital projects that TSH are progressing. These include (* indicating national projects subject to national timescales and budgets):

- Second stage roll out of windows 10*
- Office 365 Implementation of SharePoint*
- RiO upgrade
- NIS Implementation of audit recommendations
- Patient Electronic Catalogue Access
- ERostering*
- HEPMA implementation (linked to NHS Lothian)
- Cyber security

11. Staff Health and Wellbeing

TSH has adopted a tiered support model, based on the principles of psychological first aid (care, protect, comfort, support, provide, connect, and educate) as part of staff health and wellbeing approaches.

The model includes initiatives and interventions designed to raise staff awareness and facilitate access to self-help resources, psychoeducation, and peer support. Signposting and assistance to access psychological support and counselling services is also being provided when required. TSH have embedded a Staff Wellbeing Centre, which has Wellbeing Facilitators available for staff to provide in person support. TSH have committed to development of a Staff Health and Wellbeing Strategy with the intention of:

- Promoting a culture of care and concern for staff, which demands that everybody accepts responsibility for their own and others' wellbeing
- Promoting a culture of open conversation so that we talk about our wellbeing and mental health and make support available when colleagues may be experiencing challenge
- Providing support and signposting aimed at encouraging colleagues to use tools for managing total wellbeing, including mental health
- Ensuring working environments are healthy, safe, secure, and fit for purpose

The aim is to have a healthy, happy, engaged and thriving workforce. The plan is to evolve TSH health and wellbeing offer in line with the emerging and dynamic needs of staff.

12. Performance Management and Continuous Improvement

The Strategic Planning and Performance Group (SPP) met for the first time on 11 August 2021. The SPP supports the development and review of strategy in planning and performance and reports to the CMT.

As TSH engages on recovery and develops plans for the future, management of performance is vital in enabling clear direction underpinned by performance measurements. TSH has recently developed a Performance Workbook which provides a comprehensive overview of the data collected across the organisation, aligned to the corporate objectives, and the commitments of the Remobilisation Plan. TSH has recently used the Performance Measurement Blueprint approach (PuMP) with teams in HR and e-health to develop performance measures and track performance results in these areas. This approach based on continuous improvement will continue to be developed across TSH as more teams are trained in the use of this methodology.

13. Business Continuity and Resilience Planning

Resilience and emergency planning is reported through the Security, Risk and Resilience and Health and Safety Group to the CMT. There is also an annual report to the Board's Audit Committee. Resilience priorities for 2021/22 include:

- Continue to review, test, and update all Level 2 plans
- Re-introduce Incident Command Training at all levels
- Continue to develop and grow TSH relationships with partner agencies
- Increase compliance with NHS Standards for Organisational Resilience
- Finish Level 3 multiagency plan review

TSH connects with the West of Scotland Regional Resilience Partnership to network and share best resilience practice. TSH Director of Security, Resilience and Estates chairs the Contingency Planning Liaison Group which is a multi-agency group that oversees emergency planning arrangements and reports to the Lanarkshire Resilience Partnership (LRP). The LRP is chaired by the South Lanarkshire Council Emergency Planning Officer. The LRP is the lowest level of the national structure for emergency planning and reports to the West of Scotland Regional Resilience Partnership, which we link with. TSH is also linked into the NHS Resilience Forum, hosted, and chaired by Scottish Government NHS Resilience.

Shared learning and understanding continues to come from the Scottish Government Emergency Response and Preparedness Group. Lessons learned allow TSH to adapt, change and modify how we operate.

TSH continue to work closely with the Scottish Prison Service, sharing of information is key in this process, especially around those patients that come into the care of TSH from the prison setting. It is important that once the patient is admitted that relationships are maintained with the referring establishment. TSH also look to utilise training opportunities from the prison service in line with Incident Command

Relationships with Police Scotland are established. Close links have ensured there is a strengthened understanding and shared operating practice. We now have specific Police Liaisons Officer in place to maintain and develop TSH local and national relationship.

TSH's relationship with the Scottish Ambulance Service is maintained via joint working on our response plans, ensuring that both parties are up to date with specific needs and requirements.

Relationships with the Scottish Fire and Rescue Service remain strong. This is maintained via joint working on response plans ensuring that both parties are up to date with specific needs and requirements. A drive to restart regular visits is underway to allow the local responders to have an awareness and understanding of what to expect on arrival at TSH.

13.1. Business Contingency

Business Continuity Plans (BCP) are being reviewed and have been updated where required. Throughout the year, plans are in place to continue to test TSH Level 2 plans and ensure resilience. Work has also been undertaken to reconfigure the pandemic resilience plan as a result from Covid 19 and adapted to new lessons learned. We continue to engage with resilience partners to set out a plan to live test TSH multi-agency plans in the forthcoming year.

14. Workforce Plan

TSH submitted an interim Workforce Plan to Scottish Government in July 2021. This plan reiterates that the most valuable asset in TSH is our workforce. Individuals and teams across the organisation play a pivotal role in maintaining the safety and security of the site whilst delivering front line care to patients in sometimes challenging and complex circumstances. The Interim Workforce Plan outlines

stakeholder engagement, supporting staff physical and psychological wellbeing, short and medium-term workforce drivers and supporting the workforce through change.

The Interim Workforce Plan 2021/22 sets out anticipated workforce challenges due to planned retirals and outlines the range of actions planned to mitigate risks. This remains a live issue for TSH with safe staffing levels being a key priority to ensure safe delivery of care and staff wellbeing.

The configuration of TSH workforce has changed in response to Covid 19. In light of the pandemic, colleagues have been redeployed from non-ward based roles to support the ICOP and the provision of Covid 19 care, alongside a targeted recruitment exercise to increase TSH available nursing workforce.

A HR and Wellbeing Group has been established, meeting monthly, to assist in identifying and addressing local needs. This includes representation from clinical and support services, staff-side, psychological services, organisational development, and human resources. Input from the occupational health service and other relevant services is sought as and when required. Within TSH there is a nominated Wellbeing Champion who has a lead role in the co-ordination of the local response and will support the development of a staff wellbeing strategy for TSH for 2022

The Health and Care (Staffing) (Scotland) Bill 2019 has been produced with the aim to enable safe and high-quality care by making the provision of appropriate staffing in health and care statutory, resulting in better outcomes for service users. Formal work on safe staffing recommenced as in August 2021, and the local workforce lead is liaising with the Programme Advisor Healthcare Staffing Programme to identify and agree local priorities with a focus on real time staffing informed through the development of local business intelligence reporting. TSH will comply with the progression of this national work stream.

Work has commenced on the 3 year Workforce Plan which is due for submission to the Scottish Government by the 31 March 2022. This will be developed in partnership across TSH staff groups, and will include assessment of any impact from the development of the new Clinical Model. Work is also ongoing, linking into the West of Scotland HRD Group to discuss the requirements of the Region and how TSH can support the agenda to contribute to NHS Scotland's overall Workforce Plan.

14.1. Potential Female High Secure Provision

The Independent Review into the Delivery of Forensic Mental Health Services was published on 26 February 2021. The review recommended that a high secure service for women be established at TSH. At present, there are no high secure female beds in Scotland for either mental illness or intellectual disabilities. At this point, it is not known if Scottish Ministers will accept this recommendation.

A costing exercise has been completed and submitted to the Mental Health Directorate. Further discussions will determine if a female service was to be established in Scotland, where this might be sited. If TSH should become the host site for this new service, recruitment of a dedicated workforce for female high secure provision will be required.

15. Finance Plans

Due to the Covid 19 pandemic, additional specific costs are being incurred on an ongoing basis. These costs have been identified since the onset of the pandemic in March 2020, as the Hospital operates under new ways of working. Reporting and forecasting is in line with SG expectations and a next follow-up meeting is expected in October 2021.

While TSH budget for 2021/22 was drafted with an assumption that Covid 19 related costs would continue though Q1 and Q2 only, TSH monitor this position on a month-by-month basis for reporting and forecasting. This will ensure all relevant costs are included for consideration in the new year's

Covid 19 allocation process, and currently await national guidance on the approval of costs expected to be ongoing into Q3 and Q4.

Continuing in the main from 2020/21, the principal revenue costs incurred in relation to Covid 19 in 2021/22, as submitted in the Board's Q1 return and Q2 forecast are as undernoted:

- Overtime costs Q1 £130k – additional overtime incurred each month due principally to the increased levels of staff absence arising from Covid 19 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).

- Nursing recruitment £150k – these costs are to be confirmed with Scottish Government regarding the correct allocation of costs of additional student nurses to confirm if these are to be funded directly through the Covid 19 funding as in 2020/21.

- Additional deep cleaning £5k – being extra cleaning requirements specific to rooms for patients with positive Covid 19 test results.

- 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.

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

- "Dual running" staff costs – £12k – relating to Covid 19 support posts ongoing. This expenditure will be kept under review and discussions are active with the Scottish Government Finance Directorate.

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

Looking beyond 2021/22, TSH budgeting forecast for 2022/23 is set on the basis that Covid 19 related costs will no longer be ongoing by that time, and that the Hospital will have reverted to normal ways of working. As noted elsewhere, TSH are due to implement the new Clinical Model by then, the forecast will include assessment of any potential financial impact of that process.

TSH continue to set longer-term forecasts on a three-year rolling basis in order to identify any future financial pressures at the earliest opportunity in order that these can be notified to Scottish Government finance.

16. Corporate Governance Blueprint

16.1. Board Update:

Three Non-Executive Directors were appointed to the Board at the beginning of the year following a recruitment programme led by Scottish Government. A new Board Chair was appointed in July2021, and in September 2021 a new Employee Director was appointed.

These changes have opened a vacancy for Non-Executive Whistleblowing Champion. Interim arrangements are in place for any Non-Executive Director to act as a contact in relation to concerns raised through the whistleblowing process, until this vacancy is filled.

An induction programme has been implemented locally to support new board members and to align with national board development initiatives led through NHS Education for Scotland.

16.2. Board Governance Framework:

Throughout the Covid 19 pandemic, TSH Board has been able to continue to follow its existing standing orders, offering a strong governance framework through which its response to the continuing crisis has been managed. This has been kept under close review by the Board, and the existing arrangements are working effectively to provide a strong governance framework for the conduct of board business. It is recognised that the continuing risk presented by Covid 19 is high, but there are no significant risks on the horizon to suggest that this will not remain the position during the next six months, and it is the intention of the Board to continue with this framework.

Board and Committee meetings are planned to continue with the established schedule of meetings during 2021, and the schedule for 2022 will be presented to the Board at its meeting on 28 October 2021. At present meetings are being held virtually, and the Board is reviewing hybrid approaches with a mix of in-person and virtual attendance for the future. This will support the role of the Board as a national board, particularly in relation to public board meetings.

The Board has re-started focussed work on its Corporate Governance Improvement Action Plan, with progress updates being considered at its meetings in April and August 2021. Most actions have now been closed as completed, with work re-started on the remainder. The Board considers that this will be a strong basis upon which to engage with the Active Governance framework being led nationally by the Board Development Team in NHS Education for Scotland. Links have been established to plan for a board development session planned for November 2021, tailored to the unique requirements of TSH.

The Project Oversight Board for the Perimeter Security and Enhanced Internal Security Systems has continued to function and reports regularly to the TSH Board.

The advisory committee structure has continued to function led by the Clinical Forum. The Chair of the Clinical Forum is a standing invitee to both the CMT and the Board.

16.3. Management Structure:

Following the phased move out of incident command into an interim management structure on 9 December 2020, this structure was formally reviewed and agreed as a permanent structure in April 2021.

The management group structure is now well established and continues to be developed further, supported though structured approaches led by the Board Secretary through governance self-assessment tools, as well as by the Organisational Development team. This will be a continued area of focus in the next six months, particularly further development of the Hospital Management Team to support and strengthen opportunities for dispersed leadership throughout the organisation. Partnership working continues to be integral. The Employee Director is a member of the CMT, and joint staff side colleagues are involved at every level of governance.

TSH continues to recognise the risk that Covid 19 presents to the safe delivery of care to our patients, and that the incident command structure may have to be stood up in response to significant change.

Appendix 1 The Delivery Plan Progress Report Template

The attached document is The Delivery Plan Progress Report Template which provides details on the milestones, targets and deliverables outlined from TSH RMP3. The paper details the progress made in the first 6 months of the year against those commitments.

TSH Remobilisation Plan Delivery Templa

The State Hospital - Delivery Plan Progress Report Apr-Sep 2021

Key for status:

Proposal – New Proposal/no funding yet agreed
Red - Unlikely to complete on time/meet target
Amber - At risk - requires action
Green - On Track
Blue - Complete/ Target met

RAG Status **(mandatory)**	**Deliverables (mandatory)** *these can be qualitative or quantitative*	**Lead Delivery Body**	**Risks (mandatory)** *list key risks to delivery and the required controls/mitigating actions*	**Outcomes (optional)** *include outcomes if possible – repeat for each applicable deliverable/ add multiple outcomes if required*	**Strategies, plans & programmes** *repeat for each applicable deliverable/add multiple programmes if required*

Sept 21 Status	Key Deliverable Description	Summary of activities etc	Milestones/Target	Progress against deliverables end Sept 21 *(NB: for new deliverables, just indicate 'New')*	Lead delivery body	Key Risks	Controls/Actions	Outcome(s)	List any major strategies/ programmes that the deliverable relates to
Green	Digital transformation	Second stage roll out of Windows 10	December 2021	In progress, projected to be completed by end of December 2021.	TSH	Resource Equipment National delays	Prioritised staff who needed equipment during shortage. Refurbished equipment. Additional resource required and requested.	TSH will have a compliant windows operating systems that meets cyber security requirements.	Digital Inclusion Strategy
Green	Digital transformation	Office 365 implementation of SharePoint	Nationally determined milestones and targets	Scoping underway to determine file structure and identify any gaps. National changes in delivery timescales; delayed implementation of SharePoint.	TSH	Training Resource Information Governance National delays	Being compliant with national standards and take forward national guidance when this emerges.	TSH will meet national standard for our digital platform and allow collaboration between NHS Scotland and wider partners.	Digital Inclusion Strategy
Green	Digital transformation	RIO Upgrade	16 February 2022	Delivery underway to update from version 6 to 21 of the electronic patient record. This will also require support for staff users to enable use of new functionality. Technical builds are ahead of schedule and testing can commence September 2021. Expected live date of 16 February 2022.	TSH	Resource Training Project Manager not recruited.	Project Manager post in development.	Fully supported Electonic Patient Record with enhanced capabilities.	Digital Inclusion Strategy
Amber	Digital transformation	NIS Implementation of Audit Recommendations	October 2021	Next audit will be October 2021 to review current progress. Work has been ongoing to the major priorities; working through the different level of priorities and associated action plans.	TSH	Resource Cyber security Financial	Protect staff time to deliver project. Through delivering of this project, cyber security is assured.	Compliance with regulation – Network and Information Systems.	Digital Inclusion Strategy
Green	Digital transformation	Patient Electronic Catalogue	September 2021	Software issues has been resolved and testing by Security has been concluded. Pilot site has been identified and review of the equipment and processes will take place in September 2021. Feedback will be provided during this period from patients and staff prior to the equipment being rolled out to the remaining wards.	TSH	Security requirements	Identifying all potential security breaches. Controlling access to inappropriate content. Sophos firewall updated regularly.	Patients' ability to view digital catalogues.	Digital Inclusion Strategy
Green	Digital transformation	Rollout of e-roster	Nationally determined however indicative timescale of late 2022	New system is Allocate. Indicative timing late 2022. Initial project planning commenced as well as resource assessment. To be taken forward as a hospital wide project.	NSS / TSH	Project Planning Resource	Establishing hospital-wide project team and ownership. Develop project charter.	Electronic staff rostering system.	Digital Inclusion Strategy

Sept 21 Status	Key Deliverable Description	Summary of activities etc	Milestones/Target	Progress against deliverables end Sept 21 *(NB: for new deliverables, just indicate 'New')*	Lead delivery body	Key Risks	Controls/Actions	Outcome(s)	List any major strategies/ programmes that the deliverable relates to
						National delays			
Green	Digital transformation	HEPMA Implementation	March 2022	HEPMA planning underway for going live in 2022. This will be linked to NHS Lothian going live.	NHS Lothian	Projected financial risk Schedule for implementaion is aligned with NHS Lothian	Awaiting further development.	Electronic prescribing system in place, supporting safe and effective patient care.	Scottish Government e-Health Strategy
Amber	Digital transformation	Cyber security	Ongoing project.	Ongoing work to increase staff awareness on understanding the threat landscape. Increase in incident reporting for assurance purposes to accurately report risks.	TSH	Training and awareness Resourcing Financial Infrastructure updates External factors	Awareness campaigns through bulletins. Ongoing monitoring of any cyber security risks and reporting / escalating as required.	Increased awareness of cyber security at TSH with accurate reporting.	Digital Inclusion Strategy
Green	Digital transformation	Linkages with Parole Board and Tribunals	Interim solution in place currently. Tribunal suite expected to return as a fixed location in 2022.	Equipment has been provided to facilitate tribunals. This was to provide a solution for patients to attend these remotely. It is expected that parole hearings will return to the Tribunal Suite at the hospital soon. With a fixed location we can further refine our technical solution to improve the patient experience by providing larger screens and better audio.	TSH	Security	Ongoing monitoring of security risks and reporting and escalating any identified risks.	TSH has an efficient linkage to criminal justice hearings.	Digital Inclusion Strategy
Green	Digital transformation	Business Tableau	Work ongoing with dashboard development	Significant work has been undertaken on the Senior Charge Nurse dashboard to provide guidance and awareness of Tableau across TSH, particularly within nursing. Currently there are 8 active / live dashboards (patient related and anonymised), 5 additional dashboards are under development and a further 2 project proposals have been submitted for evaluation – these have been accepted by eHealth and scoping is currently underway.	TSH	Resource EPR Upgrade External Factors Competition	Significant process of change enacted via HMT to renew outdate job descriptions. Additional Data Specialist post advertised in August 2021. Continued monitoring of the eHealth systems underway.	Increased use of Tableau across the Board to provide evidenced based decision making.	Digital Inclusion Strategy
Proposal	Digital transformation	Digital media for Patients – New initiative	Early stages of development – project milestone to be agreed	The Digital Inclusion group will be exploring the available options for Digital Media solutions for patients. The use of self-service kiosks is presently being used in other high secure settings and the Prison Service. These touch screen devices are specifically designed to meet the needs of a high secure environment and located in patient rooms. They can provide access to educational resources, meal ordering, financial information and can be enabled for in room video visiting. A visit is being arranged to Addiewell Prison to view this facility in use and links have been established with Ashworth Hospital.	TSH	Significant financial implications Security Technology	Scope risks and resources involved.	Supporting digital access to patients.	Digital Inclusion Strategy Digital Participation Charter

Sept 21 Status	Key Deliverable Description	Summary of activities etc	Milestones/Target	Progress against deliverables end Sept 21 *(NB: for new deliverables, just indicate 'New')*	Lead delivery body	Key Risks	Controls/Actions	Outcome(s)	List any major strategies/ programmes that the deliverable relates to
Amber	Increase in Physical Activity and Improve the Physical Health of Patients	Seven-day model of physical activity	TSH KPI of 90 minutes of physical activity per week.	Six Activity Coordinators recruited to support activity across the wards and Hubs. Weekly timetable group meets to review activity and QI project work ongoing to support weekend activity.	TSH	Resourcing Environmental Limitations	Managerial focus and weekly monitoring of activity on ensuring continued access. Action Plan produced.	TSH will have a healthier patient population.	Forensic Network Continuous Quality Improvement Framework Mental Health Strategy 2017 - 2027
Amber	Increase in Physical Activity and Improve the Physical Health of Patients	Review of the model of activity delivery	Project plan to be developed to identify milestones	QI project work undertaken to understand the issues and scope the project. Literature review, expert opinion sought, and process mapping carried out to review the activity pathway. Driver diagram developed and initial change ideas produced. Strategic redevelopment of the wider activity pathway recommended together with wider cultural change ideas to promote physical health of patients	TSH	Resourcing Project Planning to ensure connection across projects that seek a similar outcome	Monitoring of resourcing. Ensure refreshed approaches to activity to support interest and engagement. Seasonal plan.	Engaged, active and upskilled TSH population.	Forensic Network Continuous Quality Improvement Framework Mental Health Sytategy 2017 - 2027
Amber	Increase in Physical Activity and Improve the Physical Health of Patients	Supporting Healthy Choices - involves exercise, healthy diet and healthy BMI measurement.	Consultation on Action Plan October 2021	Action Plan is out for consultation in October 2021. Funding acquired for full time programme manager; recruitment process to be enacted.	TSH	Resourcing Patient participation	Data monitoring through programme manager to identify effects of SHC Action Plan.	Healthier patient population.	Forensic Network Continuous Quality Improvement Framework Mental Health Strategy 2017-2027
Green	Organisational and Clinical Effectiveness	New Clinical Model - Delivery and Implementation	Development of project plan	This activity has been paused due to COVID-19; plan to restart engagement. Mapping exercise carried out to check model fidelity.	TSH	Resourcing Hospital capacity and wider patient flow across the forensic estate	Engagement ongoing with SG to address wider system issues.	Recovery pathway for patients flow through the hospital. Improving the environment for patients with intellectual disabilities. Improving safety.	Mental Health Strategy 2017 - 2027
Green	Organisational and Clinical Effectiveness	Improving perceptions of mental health (NEW)	Ongoing work stream.	Reduce stigma within forensic settings and mental health by creating media interest with accurate reflections of care delivery, particularly within TSH.	TSH	Reputation Negative impact on staff and patient morale Re-exposure of patients to their historical press releases	Reiteration of positive messages through media outlets. Engagement with SeeMe programme.	Improved public understanding of the role of forensic mental health services and recovery pathways. Reduced stigmatisation of mentally disordered offending.	Mental Health Strategy 2017 - 2027
Blue	Staff Health and Wellbeing	Staff wellbeing hub	Project complete.	Wellbeing hub established and permanent base secured. TSH have employed two wellbeing champions on a part time basis (30 hours per week) to provide dedicated support for staff health and wellbeing and ongoing development of initiatives.	TSH	Attendance Resource	Continue to promote the wellbeing hub, particularly at times of pressure within TSH.	One of the Wellbeing Champions commenced 31 August with the second post	Staff Wellbeing and Support: Employers' Duty of Care During covid-19 Pandemic. https://www.sehd.scot.nhs.uk/dl/DL(2020)08.pdf)

Sept 21 Status	Key Deliverable Description	Summary of activities etc	Milestones/Target	Progress against deliverables end Sept 21 *(NB: for new deliverables, just indicate 'New')*	Lead delivery body	Key Risks	Controls/Actions	Outcome(s)	List any major strategies/ programmes that the deliverable relates to
							Monitoring of resources available to ensure that needs are met.	commencing on 5 October. Work has commenced with them looking to provide additional support to staff. Pastoral Support post is currently out to advert within NHS Lanarkshire.	
Green	Staff Health and Wellbeing	Staff feedback and engagement	27TH Sept – Completion of I-matter questionnaire Analysis of data in Pulse survey by end September	<u>iMatter:</u> 48% Response Rate as at 15th September. Survey closes on 27 Sept. Draft Wellbeing Strategy is current in Version 1 and will be circulated for comments. Psychology colleagues currently analysing the data from the second wellbeing pulse survey. This is expected by end of Sept.	TSH	Poor participation rates by staff in the consultation and surveys	Frequent communication through range of media to encourage staff participation Support of managers to encourage staff participation	Objective feedback form staff on their experience of working in TSH and views on future strategy	Staff Wellbeing and Support: Employers' Duty of Care During covid-19 Pandemic. https://www.sehd.scot.nhs.uk/dl/DL(2020)08.pdf)
Green	Staff Health and Wellbeing	Coaching available for TSH staff through national online coaching hub and collaboration with NHS Lanarkshire and TSH staff	Coaching offers ongoing	Coaching hub is available and being promoted through staff bulletins. Increased awareness of coaching uptake, in progress – flyers, posters etc have been promoted and will be circulated again over coming weeks Coaching: • 5 NHS Scotland external staff and 15 staff TSH being coached by TSH coaches. • 2 TSH staff receiving and 2 external NHS staff receiving coaching from NHS Lanarkshire/TSH collaborative coaching programme • Coaching Collaborative (NES) coaching 2 NHS Scotland Staff and 2 from TSH.	TSH NES NHS Lanarkshire	Attendance Resources	Support for staff to prioritise coaching opportunities	Data from National Wellbeing Hub currently being sought on TSH staff uptake to date.	Staff Wellbeing and Support: Employers' Duty of Care During covid-19 Pandemic. https://www.sehd.scot.nhs.uk/dl/DL(2020)08.pdf)
Green	Staff Health and Wellbeing	Provision of psychological first aid training and coaching for managers	Learn pro module has good uptake in staff groups across TSH	Consideration of Psychological First aid training and looking at input form the Psychology Dept to support this training. Looking to continue to prioritise this. In addition, a new on-line module has been added on LearnPro 'Protecting the Psychological Wellbeing of Staff and Teams'. This is a resource that was developed by NES. The purpose of the module is to help Managers and Team Leaders understand the evidence-based factors that support the wellbeing of managers and teams through crisis events such as COVID-19. It contains information about proactive prevention strategies that managers can apply to protect the wellbeing of their staff, and reactive intervention strategies to respond effectively and promptly to concerns about an individual's mental health during and after the crisis.	TSH NES	Time to complete Resources	Support for staff to prioritise training	Staff and managers have increased awareness of strategies to protect psychological wellbeing	Staff Wellbeing and Support: Employers' Duty of Care During covid-19 Pandemic. https://www.sehd.scot.nhs.uk/dl/DL(2020)08.pdf)

Sept 21 Status	Key Deliverable Description	Summary of activities etc	Milestones/Target	Progress against deliverables end Sept 21 *(NB: for new deliverables, just indicate 'New')*	Lead delivery body	Key Risks	Controls/Actions	Outcome(s)	List any major strategies/ programmes that the deliverable relates to
Green	Staff Health and Wellbeing	Support projects for staff wellbeing	Information sessions and Campaigns delivered Excellence awards 30th November	Healthy Working Lives and National Wellbeing Promotion <u>April – June</u> • Stress Awareness Information Campaign • Mental Health Awareness Week • Men's Health Week & Quiz • Wellbeing Webinars • Pre-retirement workshop • Active Commute <u>July – September</u> • Pride Pledge • MacMillan Coffee Morning • Performance Medicine Programme • Wellbeing Webinars <u>Excellence Awards:</u> 88 nominations received. Longlisting and shortlisting taken place. MS Teams Live event on track for 30th November.	TSH	Time Resources Financial	Regular meetings held to support the range of staff health initiatives Financial resource available	Staff groups are supported and recognised for their contribution Staff health and wellbeing supported and enhanced Staff awareness raised of how to prevent health deterioration	Staff Wellbeing and Support: Employers' Duty of Care During covid-19 Pandemic. https://www.sehd.scot.nhs.uk/dl/DL(2020)08.pdf)
Amber	Building a personalised approach to care	Revision of the process for delivery of the Care Programme Approach	Early 2022	MHPSG is reviewing the CPA approach to ensure its validity to individuals, carers and clinicians.	TSH	Conflicting requirements of individual needs.	A detailed examination of each aspect of the CPA process.	Effective and efficient CPA Approach that engages patients and carers which meets legal requirements.	Mental Health Act requirement.
Green	Building a personalised approach to care	Enhance and improve visitor experience	December 2021	In person visiting recommenced in April 2021 and continues be facilitated safely, compliant with national infection control guidance. The interim visiting model is currently being reviewed, aligned to the Clinical Service Model Delivery. Positive feedback has been received from all stakeholders. A report outlining benefits and risks in relation to the current centralised visiting environment is scheduled for discussion at CMT in December 2021.	TSH	Resourcing Financial Visitor Experience	Reviewing current arrangements and ensuring appropriate control are in place for the safe delivery prior to implementation.	Safe delivery of visiting.	Person Centred Visiting Guidance
Amber	Safety and Security	Perimeter Security and Enhanced Internal Security Systems Project	The planned completion date has moved from mid-October 2021 to 2 March 2022 due to impact of COVID related delays.	The project has continued with CCTV installation across the Hubs, grounds and patient walkways, car park and outer perimeter. Replacement of Fence detection systems. The project is proceeding according to the current projected cost plan. Off-site works included the production and review of:	TSH Stanley Construction	Finance Security Resources	Monitoring of risks through the project risk register and monthly Project Board Meetings.	Upgraded security systems across TSH hubs, grounds and perimeter.	

Sept 21 Status	Key Deliverable Description	Summary of activities etc	Milestones/Target	Progress against deliverables end Sept 21 *(NB: for new deliverables, just indicate 'New')*	Lead delivery body	Key Risks	Controls/Actions	Outcome(s)	List any major strategies/ programmes that the deliverable relates to
				• 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					

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	23 December 2021
Agenda Item:	Item No. 7b
Sponsoring Director:	Director of Finance and eHealth
Author(s):	Director of Finance and eHealth
Title of Report:	Financial Governance – Covid-19 / Digital update
Purpose of Report:	Update on Covid financial impact / Digital developments

1 SITUATION

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

2 BACKGROUND

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

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

For 2021/22, on a similar timing basis to 2020/21, an initial report – for the three-month period April-June (Q1) – was submitted to SG in July, with a similar report for July-September (Q2) prepared and submitted 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 scheduled to the year-end, and indeed into 2022/23.

Discussion has been had with SG to review the likely requirement for 2021/22 Q3 and Q4, and initial estimates now for 2022/23. 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, instead we reported Covid costs through Q1/2, with allocations therefrom 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 determined on an estimate towards the March 2022 year-end.

We 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 follow-up discussions are confirming support to cover our Covid-related costs through to March 2022.

Our budget for 2022/23 is now being drafted with an initial assumption that Covid-related costs will continue through at least Q1 and Q2, and we will monitor this position to ensure we reflect the necessary period of likely cost pressures in line with SG guidance as it develops.

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 Q3/4 forecast are as undernoted.

i. Overtime costs Q1&2 £60k – 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 as expected these are to be funded directly through the Covid funding as in 2020/21. This is also a key area for consideration for 2022/23.

iii. Additional deep cleaning £6k – being extra cleaning requirements specific to rooms for patients with positive Covid test results.

iv. Telephony, related IT and digital costs £4k – 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 – £60k – 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. Should further restrictions be applied in December 2021/January 2022 then this will require additional consideration.

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.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	23 December 2021
Agenda Reference:	Item No: 09
Sponsoring Director:	Director of Nursing, AHPs and Operations
Author(s):	Person Centred Improvement Lead
Title of Report:	Person Centred Improvement Service Report 2020/21
Purpose of Report:	For Noting

1 SITUATION

The remit of the 'Person Centred Improvement Service' (PCIS) includes work streams emerging from:

- Person-centred improvement projects.
- Stakeholder involvement.
- Volunteer Services.
- Carer support.
- Spiritual and Pastoral Care.
- Equality Agenda.
- Supporting the role of the Patients' Advocacy Service (PAS).
- Since July 2020, the PCIS have undertaken the role of implementing the centralised visiting model as part of the organisational response to mitigating the impact of Covid-19.

2 BACKGROUND

The State Hospital's Person Centred Improvement Service Delivery Plan builds on the national commitment to provide services developed through "mutually beneficial partnerships between patients, their families and those delivering healthcare services, which respect individual needs and values and which demonstrates compassion, continuity, clear communication and shared decision-making" (Scottish Government, 2010).

This report relates to the period November 2020 to October 2021 and provides an update in respect of the above work streams under the umbrella of 'person-centred care', in relation to contributing to the delivery of high quality care and treatment which is based on individual need.

Extensive partnership working with external stakeholder groups continues, including the Scottish Government Person Centred Stakeholder Group, Health Improvement Scotland Community Engagement, Volunteer Scotland and Carers' Trust Scotland to ensure that the Board continues to discharge its duties, where appropriate, adopting a tailored approach which reflects the needs of patients in its care.

3 ASSESSMENT

Key Performance Indicators

- 10 of 15 outcome measures were achieved
- 3 of those partially achieved are directly as a result of the impact of Covid-19.

The report highlights key achievements including:

- Facilitated the Hospital wide WMTY initiative.
- Embedded and further developed the centralised visiting model.
- Developed Carers' Representative Role Descriptor and training programme.
- Developed and implemented TSH Volunteer Impact Assessment.
- Supported implementation of the patient internet shopping browsing experience.
- Reinstated delivery of Spiritual and Pastoral Care Services.
- Developed Volunteer Visitor programme.
- Published TSH Equality Outcomes.
- Influenced development of the national 'Quality Framework for Engagement'.
- Contributed to development of local 'Essentials of Safe Care' framework.
- Variety of stakeholder narratives shared with the Board.

Challenges

- Competing priorities as a result of increased workload relating to visiting, impacting on delivery of core function.
- 'Flat' service workforce structure, need for future proofing in terms of succession planning.
- Implementing person-centred visiting, aligned to national guidance.

Actions for the next twelve months include:

- Tailor national 'Interpretation and Translation Policy' for implementation locally.
- Develop Carers' Policy.
- Develop Action Plans for all Equality Outcomes.
- Support achievement of updated Supporting Healthy Choices Plan.
- Implement national Quality Framework for Engagement.
- Adapt EQIA process to incorporate inclusion of updated Fairer Scotland Duty.
- Undertake service review to support capacity and resilience at operational and leadership level.
- Develop local volunteer drivers' scheme.
- Develop Carers' Needs Support Plan.

4 RECOMMENDATION

The Board are invited to*:*

- Note the progress outlined in the Report.
- Note the emerging issues, learning opportunities and key actions for the next twelve months.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives?	Supports delivery of the Person Centred Improvement Service remit and person-centred deliverables within TSH Re-mobilisation Plan.
Workforce Implications	As highlighted
Financial Implications	As highlighted
Route to the Committee *Which groups were involved in contributing to the paper and recommendations?*	Person Centred Improvement Steering Group Patient Partnership Group Carers' Support Group Volunteer Service Group Clinical Governance Group Corporate Management Team
Risk Assessment *(Outline any significant risks and associated mitigation)*	No significant risks identified
Assessment of Impact on Stakeholder Experience	Captures feedback relating to stakeholder experience and provides opportunities to develop systems / processes through which learning from feedback informs service design. Supports Board's commitment to assessing the impact of service delivery on stakeholder experience.
Equality Impact Assessment	Includes detailed reference to this requirement.
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).	Highlights pending changes.
Data Protection Impact Assessment (DPIA) See IG 16	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

PERSON CENTRED IMPROVEMENT SERVICE

TWELVE MONTH UPDATE REPORT

NOVEMBER 2020 - OCTOBER 2021

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1. Introduction

The 'Person Centred Improvement Service' (PCIS) supports services across The State Hospital (TSH) through its diverse work streams contributing to achievement of strategic objectives specifically relating to:

- Person-centred improvement projects (Person-centred Health Care Programme (ref 1)).
- Meaningful stakeholder involvement: patients, carers, volunteers, and the public (limited to external regulatory/supporting bodies and third sector partners).
- Volunteer Services.
- Carer / Named Person / visitor support.
- Spiritual and Pastoral Care.
- Equality Agenda.
- Supporting the role of the Patients' Advocacy Service (PAS).

During this reporting period, the PCIS have also had responsibility for facilitating and making ongoing improvements to the interim visiting model.

This report relates to the period November 2020 to October 2021, during which time the service continued to support wider disciplines including nursing and medical colleagues in terms of a range of national drivers e.g. 'Realistic Medicine' (Scottish Government, 2016) (ref 3), 'Excellence in Care' (Scottish Government, 2015) (ref 4) and the 'Scottish Patient Safety Programme' (ref 22), which make explicit the need to ensure that stakeholder feedback is embedded within service design.

Constraints relating to managing the impact of Covid-19 have affected service delivery during this reporting period, impacting on objectives agreed in the autumn of 2020. However, the PCIS have remained focussed on the delivery of multiple objectives throughout this period.

The State Hospital's Board (the Board) is committed to continuously improving systems and processes which support safe, effective, person-centred care, adopting a balanced and proportionate response to legislative and national drivers including:

- The Framework for NHS Scotland: 'Re-mobilise. Recover, Redesign' (2020) (ref 21)
- Mental Health Strategy (2017-2027) (ref 5).
- British Sign Language (BSL) National Plan (2017-2023) (ref 10).
- Patient Rights (Scotland) Act (2011, updated 2019) (ref 12).
- Volunteering for All: Our National Framework (2019) (ref 15)
- Fairer Scotland Duty (2018) (ref 14).
- Rights in Mind (2017) (ref 7).
- Safety and Protection of Patients, Staff and Volunteers in NHSScotland (2017) (ref 8).
- Public Sector Equality Duty (2016) (ref 9).
- Health and Social Care Delivery Plan (2016) (ref 6).
- Carers (Scotland) Act (2016) (ref 13).
- The communication equipment and support legislation (part of the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016) (ref 19).
- National Health and Wellbeing Outcomes (2014) (ref 20).
- Equality Act (2010) (Specific Duties) (Scotland) (ref 11).

Partnership working continues with key external stakeholder groups, including, however not limited to, the Scottish Government Person Centred Stakeholder Group, Mental Welfare Commission, Forensic Network partners, Mental Welfare Commission, Health Improvement Scotland Community Engagement (HISCE), Scottish Human Rights Commission, Volunteer Scotland and Carers' Trust (Scotland) to support the Board to discharge its duties.

2. Governance arrangements

The Person Centred Improvement Steering Group (PCISG), chaired by the Director of Nursing, Allied Health Professions and Operations, meet monthly to monitor progress in respect of the mainstreaming of processes supporting delivery of the above remit. This multi-disciplinary group ensures the organisation is compliant with legislative requirements and supports the service to respond to national drivers and embed local practice relating to the above portfolio. The patient Chair of the Patient Partnership Group (PPG), members of the Carers' Support Group and Volunteer Service Group are included within the core membership, in addition to representatives from HISCE and the Patients' Advocacy Service (PAS).

The group discuss a wide range of monitoring reports including:

- Patient and Visitor Experience.
- Volunteering input.
- Spiritual and Pastoral Care input.
- Progress to TSH Equality Outcomes (2021-25).
- Progress to TSH British Sign Language (BSL) Action Plan (2018-24).
- Advocacy input.
- Service Accessibility for Protected Characteristic groups.
- Learning from Complaints and Feedback.
- Person Centred quality improvement projects.

In recognition of the value of maximising opportunities to embed patient and carer experience in service design, the 'Learning from Feedback' Report is also included within quarterly monitoring reports presented to the Organisational Management Team (OMT), Clinical Governance Group (CGG) and Clinical Governance Committee (CGC).

3. Key pieces of work undertaken

- Facilitated the Hospital wide WMTY initiative.
- Embedded and further developed the centralised visiting model.
- Developed Carers' Representative Role Descriptor and training programme.
- Developed and implemented TSH Volunteer Impact Assessment.
- Supported implementation of the patient internet shopping browsing experience (appendix 1).
- Reinstated delivery of Spiritual and Pastoral Care Services.
- Developed Volunteer Visitor programme.
- Published TSH Equality Outcomes.
- Influenced development of the national 'Quality Framework for Engagement' (QFE) (replaces 'Participation Standards'), supporting the delivery of effective engagement, developing practice and shared learning.
- Contributed to development of local 'Essentials of Safe Care' framework.
- Variety of stakeholder narratives shared with the Board.
- Contributed to development of the national Scottish Patient Safety Climate Tool refresh.

4. Wider Local Input

The Person Centred Improvement Lead (PCIL) is a member of TSH Quality Improvement (QI) Forum, supporting the spread of QI skills across the Hospital. The PCIL uses formal QI qualifications and experiential learning to provide mentoring input across the Hospital directly relating to person centred improvement initiatives including:

- Equality of access for Protected Characteristic Groups
- Shared decision making through meaningful patient and carer involvement in the CPA process.
- Supporting patients to make healthy choices.
- Visiting experience.
- Patient digital inclusion.
- Refresh of TSH Clinical Service Delivery Model.

These skills have also been used to support collaborative QI projects with external colleagues including:

- Assessing the impact of volunteering.
- Review of NHS Spiritual and Pastoral Care standards.
- NHS Interpretation and Translation Processes.
- Quality Framework for Engagement
- Review of Fairer Scotland Duty (2018)

5. Key performance indicators

	Improvement Indicator	***Outcome Measures***
1.	Patients from all areas of the Hospital are meaningfully engaged in contributing to service design.	a) Patient Partnership Group (PPG) is facilitated 50 weeks of the year. b) PPG membership includes representation from all wards. c) An average of 10 patients attend PPG each week. d) PPG engage with a wide range of internal and external partners.
2.	Patients who have no visitors have the opportunity to receive visits.	a) Recruit and train 3 new volunteer visitors.
3.	Wider patient attendance at group based spiritual & pastoral care activities.	a) Attendance mirrors national average trend (8.9%) (ref 16).
4.	Progress to TSH BSL Action Plan (2018-24)	a) 14 of total of 18 indicators achieved
5.	Carers are enabled to contribute meaningfully to patient outcomes.	a) Undertake cycle 4 Triangle of Care assessment (ref 17). b) 'Green' level achieved for 80% of indicators.
6.	Local policies have undergone an Equality Impact Assessment (EQIA), prior to implementation, which is fit for purpose.	a) 100% of all locally generated policies have an approved EQIA. *b)* 10% increase in quality compliance scores when compared to 2019/20.
7.	Publication of updated Equality Outcomes by end of April 2021.	a) All Directors engaged in collaborative development. b) Robust prioritisation process undertaken, based on the needs of Protected Characteristic Groups, based on stakeholder feedback.
8.	Facilitate national 'What Matters to You?' initiative, engaging all stakeholders.	a) Engagement with patients, carers, volunteers and staff. b) Patient feedback aligns to Person Centred Feedback database indicators.

1) Patients from all areas of the Hospital are meaningfully engaged in contributing to service design

a) PPG facilitated 50 weeks of the year (target of less than 52 weeks, accounts for 2 weeks' holidays requested by the group during the Festive period.)

Delivery to outcome measure a): Partially achieved.
PPG was suspended in March 2020 as a result of the impact of Covid-19. Where it has been possible to do so (around ward closures relating to the need to mitigate infection), the PCIS have continued to engage with PPG members on a weekly basis as part of the ward outreach involvement programme. The PPG Chair met regularly with the PCIS throughout this period to support continuity of his role. The sub-group of PPG, formed specifically to understand the experience of patients with an Intellectual Disability in June 2020, has been facilitated within the ward since then, ensuring that feedback from these patients is actively encouraged, supported and shared. Despite endeavours to facilitate patient involvement virtually using the video conferencing system, this proved to be unsatisfactory with PPG members stating they would prefer to continue with the 1:1 in-person contact model until such time as PPG could meet as a Hospital wide group. PPG resumed mid-July 2021 as part of the phased re-introduction of Hospital wide patient groups.

b) PPG membership includes representation from all wards

Delivery to outcome measure b): Achieved.
100% of wards represented. Succession plan in place to ensure continuity of involvement as patients transfer to step down services.

c) An average of 10 patients attend PPG (Target of ten patients influenced by total number of people in the group, including staff and visitors in relation to environmental Health and Safety restrictions, safety and security when working with large patient groups and ensuring all patients have the opportunity to engage meaningfully).

Delivery to outcome measure c): Achieved.
Attendance at meetings fluctuates depending on the mental health presentation of group members and requirement to attend tribunals, external clinical appointments and / or prescribed group therapeutic intervention which cannot be scheduled around the PPG timetable. The average attendance was 10 patients.

d) PPG engage with a wide range of professionals and external partners

Delivery to outcome measure d:) Partially Achieved.
The curtailed operational period impacted on the planned timetable of engagement with wider stakeholders. Catering staff and PAS have continued to support PPG since meetings recommenced. Recently appointed non-Executive Board members have been invited to attend PPG when orientation and induction processes are complete. HISCE have not yet recommenced engagement in in-person external meetings, however receive minutes of the PPG forum and engage virtually with the PCIT to support the work of the group.

2) Patients who have no visitors have the opportunity to receive visits

a) Recruit and train 3 new volunteer visitors

Delivery to outcome measure a): Achieved.
Volunteer recruitment suspended mid-March 2020 due to Covid-19 restrictions was re-opened in April 2021. Applications from 8 potential visitors are currently being progressed. Volunteer visitors recommenced input in April 2021, including input from 3 existing patient activity volunteers, unable to undertake these roles, as they were suspended at that time, who agreed to adapt their roles to provide this input. All three have confirmed they will continue to visit patients in addition to undertaking their original volunteer roles.

3) Wider patient attendance at group based spiritual & pastoral care activities (Church, RC Mass, Christian Fellowship, 1:1 ward based input)

a) Attendance mirrors national average trend (8.9%)

Delivery to outcome measure a): Achieved.
As was the case with all front-line patient groups, Spiritual and Pastoral Care activities were suspended in March 2020. The Chaplains continued to offer remote 1:1 support via telephone throughout the height of the pandemic and prepared materials each week which were printed for patients who would normally attend denominational services of worship to engage in 1:1 spiritual reflection.

All Spiritual and Pastoral Care Activities resumed in August 2021 with a significant increase in applications for patients wishing to attend. 11% of TSH patients currently engage in some form of Spiritual and Pastoral Care activity. Due to current limitations on room capacity, a waiting list is now in place for all 3 groups. Patients who have not been offered a place are offered 1:1 ward based chaplaincy input.

4) Progress to TSH BSL Action Plan (2018-24)

a) 14 of total of 18 indicators achieved

Delivery to outcome measure a): Partially achieved.
Actions to support completion of 13 indicators complete. One of the outstanding actions has been impacted by lack of progress at a national level as a result of Covid-19. This national policy has now been implemented and a gap analysis is currently being undertaken locally. One of the other outstanding actions has been incorporated within the wider Digital Inclusion work streams to support progress. Remaining 5 indicators on target for completion by 2023.

5) Carers are enabled to contribute meaningfully to patient outcomes

a) Undertake Cycle 4 Triangle of Care assessment

Delivery to outcome measure a): Achieved.
b) 'Green' level achieved for 80% of indicators

Delivery to outcome measure b): Achieved. 82% = 32 indicators (figures in brackets relate to outcome of cycle 3 assessment)

Standard	Red	Amber	Green	Indicators x
No. 1: Carers/Named Persons and their essential role are identified at first contact or as soon as possible afterwards.	0 (2)	0 (2)	8 (4)	8
No. 2: Processes are in place which ensures staff are aware of the role of carers/named persons.	1 (1)	1 (1)	1 (1)	3
No. 3: Policy and practice protocols regarding confidentiality and information sharing are in place.	2 (2)	1 (1)	5 (5)	8
No. 4: Defined post(s) and networks responsible for carer support are in place.	0 (0)	1 (1)	4 (4)	5
No. 5: A comprehensive introduction to the Hospital and processes to support ongoing involvement throughout the care journey is in place.	1 (2)	0 (0)	11 (10)	12
No. 6: A range of carer support mechanisms are available.	(0)	(0)	3 (3)	3
Total	**4 (7) -3**	**3 (5) -2**	**32 (27) +5**	**39**

Final assessment cycle is scheduled for November 2021, following which time an external panel of Forensic Network and Third Sector partners will support the ratification process.

6) Local policies have undergone an EQIA, prior to implementation, which is fit for purpose

a) **100% of all locally generated policies have an approved EQIA**

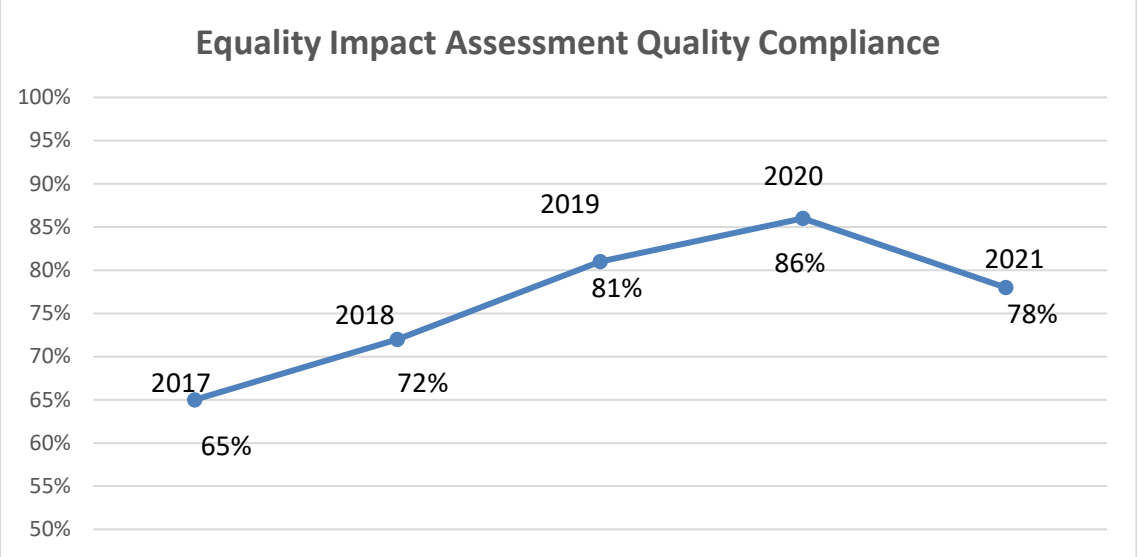
Delivery to outcome measure a): Not achieved

As of September 2021, 114 of the 130 TSH policies in place have approved EQIAs, representing 88% of all policies. Comparative data to the same period in 2020 indicates a decrease from 38 outstanding EQIAs to the current deficit of 16. The Policy Approval Group, (PAG) formed in 2020, to support a more proactive approach to ongoing improvement, continue to monitor and act on any areas of concern.

b) 10% increase in quality compliance scores when compared to 2020

Delivery to outcome measure b): Not achieved

Concerns highlighted to PAG in relation to quality of EQIAs completed, representing an 8% decrease in quality compliance. Issues relating to staff who have not completed the EQIA training prior to undertaking this assessment. New process developed to ensure that Directors assume responsibility for ensuring that staff tasked with developing / refreshing polices have attended EQIA training in order to equip them with the appropriate skills to undertake this complex assessment.



The data continues to indicate a need for improvement in relation to understanding the impact of policies / protocols, specifically in relation to the Protected Characteristic groups**.** The characteristics relating to ‘disability’, ‘age’, ‘race/ethnicity’ and ‘religion/belief’ are of particular relevance to the organisation in the context of the refresh to the Clinical Services Delivery Model as the organisation considers how best to group patients within specific wards.

7) Publication of updated Equality Outcomes (appendix 2) by April 2021

a) All Directors engaged in collaborative development

Delivery to outcome measure a): Achieved

Virtual seminars took place with all Directors, following which Service Leads were allocated responsibility to undertake the follow-up work required to develop draft Equality Outcomes. A total of 13 opportunities emerged highlighting potential to improve the experience of Protected Characteristic Groups within TSH.

b) Robust prioritisation process undertaken, based on the needs of Protected Characteristic Groups

Delivery to outcome measure b): Achieved

The Equality Outcome Priority Criteria template was used to agree on outcomes which could be realistically achieved, given the current challenges relating to Covid-19 and the complexity of the work required to implement the refreshed Clinical Service Delivery Model.
When scrutinising the supporting evidence, it was agreed that 3 related to linked inequalities and could reasonably be combined to form a single outcome and a further 2 were very similar and could be merged. Three inequalities identified have not been progressed through the Equality Outcomes work streams as they relate to legislation, existing national work streams and changes to local processes already underway. A total of 7 outcomes were therefore prioritised.

The majority of the Equality Outcomes developed from stakeholder correlate with wider corporate objectives, including the Clinical Service Delivery Model, least restrictive practice, digital inclusion, equity of access for patients with an Intellectual Disability, supporting healthy choices, shared decision making and staff wellbeing. It is therefore reassuring that this piece of work offers additional evidence to support existing work streams working on improvements which will mitigate potential health inequalities for the Protected Characteristic Groups.

8. Facilitate national 'What Matters to You?' initiative, engaging all stakeholders

a) Engagement with patients, carers, volunteers and staff

Delivery to outcome measure a): Achieved

In previous years, those engaging in the 'What Matters to You?' initiative has been limited to patients, carers and volunteers, mirroring national practice. However, in recognition of the very challenging situation all stakeholders have experienced since March 2020, the decision was taken to extend this initiative to include *staff.

This year we heard about how patients coped with a more limited model of care (appendix 3), the challenges for families unable to visit, volunteers coming to terms with losing valued roles, staff responding to different ways of working, including the isolation of those who were shielding, the onus of balancing home-schooling with home-working as well as many other aspects of living and working through a pandemic.

Reflections were brought to life through images, which are being used to build jigsaws which will be mounted for display throughout the Hospital.

*staff feedback will be shared through the HR and Wellbeing Group reporting structure.

b) Patient feedback aligns to Person Centred Feedback database indicators

Delivery to outcome measure b): Achieved

The local feedback database was developed in collaboration with external partners, enabling TSH to contribute to collation of national data sets specific to six core person-centred principles, informed by the experience of patients and carers, specifically in relation to mental health service delivery:

i) Person centred values.
ii) Effective communication.
iii) Physical comfort.

iv) Emotional support.
v) Effective relationships.
vi) Access to care.

Ongoing feedback is mapped to these principles within the quarterly 'Learning from Feedback Report', from which service improvement opportunities are progressed. Feedback relating to the importance of effective relationships are a regular theme, as is the need to ensure that patients are treated as individuals with discrete needs.

Key performance indicator overall performance

10 of 15 outcome measures achieved. 3 of those partially achieved are directly as a result of the impact of Covid-19. A plan is in place to support achievement of the remaining 2 relating to the equality agenda.

6. Overview of service remit

Equality and Diversity Agenda

Equality, Diversity and Rights Training continues to be delivered via the mandatory online module. The half day interactive in-person workshops were suspended in March 2020 however recommenced in September 2021. As is the case with the majority of in-person training programmes, there is therefore currently a delay in access to this training, also impacted by wider resourcing challenges.

As a result of restrictions on in-person training, EQIA training has been delivered virtually since March 2020. 1:1 input continues to be provided to support policy authors to engage in this area of policy development to ensure a proactive approach to mitigating potential health inequalities (ref 20).

The EQIA process highlights the needs of those with barriers to effective communication impacting on the recovery process who require 'Augmentative and Alternative Communication' (AAC) (ref 19).

The Fairer Scotland Duty (2018) (ref 14) places responsibility on the organisation to consider inequalities of outcome caused by socio-economic disadvantage when making strategic decisions. Following consultation on the draft updated guidance (2021), it is likely that the recommendation to incorporate this duty within the EQIA process will form part of the refreshed framework due to be published in 2022. The NHS Equality Lead network is currently informing development of the refresh.

Enabling Patients to share Feedback Contributing to Service Design

Patient feedback continues to be shared via the Operational Model Monitoring Group. This approach supports a rapid response to patient and carer feedback, which informs ongoing iterative changes to operational protocols driving service recovery.

The PPG have a dedicated service improvement meeting each month in order to ensure that patients are appraised of developments and encouraged to offer feedback contributing to the Digital Inclusion programme, Supporting Healthy Choices and Clinical Service Delivery Model refresh.

The views of stakeholders contribute to informing service design locally through:

- Hospital Management Team.
- OMT.
- Clinical Governance Group.
- Patient Active Day Project Group.
- Patient Safety Group.
- Supporting Healthy Choices Group.
- Digital Inclusion Group.

- Mental Health Practice Steering Group.
- Clinical Forum.
- QI Forum.
- Service change consultation / Short Life Working Groups.

The PCIL ensures the unique needs of TSH stakeholders are shared in respect of influencing the national person-centred landscape, through membership of external groups including:

- NHS Person-centred Leads.
- NHS Equality Leads.
- Scottish Government Person Centred Stakeholder Forum.
- Scottish Government Visiting Reactivation Steering Group
- NHS/Third Sector Volunteer Leads.
- Scottish Government Cross-Party Volunteering Forum.
- NHS Spiritual and Pastoral Care Leads.
- HISCE QFE Development Group.
- National AAC Advisory Group.

Volunteer Input

Pre-Covid, 15 volunteers provided a wide range of input to complement service delivery across the Hospital. Volunteer input ceased in March 2020 with 3 volunteers no longer available as a result of taking up full-time employment. Applications continued to be submitted during this period, which have since been screened. There are currently a total of 10 applications being followed up.

Volunteer Visitors returned in April 2021, with Spiritual and Pastoral Care volunteers resuming their roles in August 2021. Discussions are taking place at present to support Skye Centre Patient Activity volunteers to resume based on a peripatetic model rather than being affiliated to one activity centre. This more flexible approach will ensure that volunteers can continue to provide input each week if changes to the activity timetable are required at short notice.

Carer Support

The Triangle of Care assessment has highlighted some valuable learning in terms of understanding the lived experience of carers associated with TSH patients. One of the key points emerging is the importance placed on shared decision making and its value within the Care Programme Approach process. Insight into the needs of carers at different stages of their journey through TSH will continue to inform the refreshed Clinical Service Delivery Model.

The well-established local practice of offering financial support to visitors travelling to the Hospital is recommended to wider forensic settings (Independent Review into the Delivery of Forensic Mental Health Services, 2021) (ref 18).

As a result of the impact of Covid-19, in addition to national transport issues, there have been some challenges in respect of visitor travel: costs have risen significantly, trains to local stations have reduced in frequency, infection rates continue to fluctuate impacting on ward closures and, as a result, access for visitors, and visitors are reluctant to use public transport. There are a number of visitors who have physical heath / mobility issues and are unable to travel independently.

Work is underway with Third Sector partners to explore the development of a TSH volunteer drivers scheme which will deliver an individually tailored approach to support those most in need of such input to visit regularly.

The Carers' Support Group and Carers' Trust (Scotland) are in the early stages of engaging with TSH in a piece of work to identify opportunities to enhance carer involvement by developing a Carers' Needs Support plan. Forensic Network partners will be invited to contribute to this initiative moving forward.

The interim visiting model introduced in July 2020 remains in place. Feedback indicates that this approach continues to be well received by all stakeholders.

A short life working group, commissioned by the Corporate Management Team (CMT) to consider the viability of implementing this practice as a permanent visiting model is currently underway. Recommendations are due to be shared with CMT in November 2021.

In order to support a consistent approach to engaging the Carers' Representative and ensure training is embedded within the support mechanisms for this role, TSH Carers' Representative role descriptor was developed in collaboration with the Carers' Support Group and Carers' Trust (Scotland). This piece of work has offered a helpful opportunity to review the role of this member of the Person Centred Improvement Steering Group, specifically in relation to responsibilities, aspirations and safeguarding information.

Patients' Advocacy Service (PAS)
The PCIS continue to support the role of PAS, ensuring that the PAS Patient Board member is able to attend regular meetings and participate fully in the PAS AGM. Meetings have been facilitated virtually since March 2020, however in-person meetings recommenced in September 2021.

The PCIL meets regularly with the PAS Manager to discuss forthcoming Mental Welfare Commission visits, and general feedback, ensuring PAS remain fully involved in all aspects of service delivery and maximising opportunities for collaborative learning.

The Person Centred Improvement Advisor, PAS Manager and Complaints Officer meet regularly to share feedback from patients, identify trends / themes and use a triangulated approach to analyse the data included within the quarterly 'Learning from Feedback' Report.

7. Progress to previous key actions

	Action	**Outcome**	**Comment**
1.	Tailor national 'Interpretation and Translation Policy' for implementation locally.	Outstanding	National policy was delayed by 9 months as a result of Covid-19. Now published.
2.	Develop Carers' Policy.	Outstanding	Delayed due to resourcing challenges and additional workload relating to operational responsibility for visiting.
3.	Adapt local Volunteer Impact Assessment to incorporate national volunteering framework.	Complete	Now in use. Outcomes to be included in future Board Reports.
4.	Support Hospital wide working group to identify and explore options to develop an enhanced visiting experience aligned to the refreshed Clinical Service Delivery Model.	Ongoing	SLWG commenced September 2021.
5.	Undertake QI project to increase the number of patients receiving visits.	Ongoing	Scoping exercise underway to identify potential barriers to in-person visiting.
6.	Publish Equality Outcomes Report to national standards.	Complete	7 outcomes identified to support a more inclusive approach for Protected Characteristic Groups.
7.	Support progression of the digital agenda to enhance patient and carer involvement.	Ongoing	Internet shopping browsing experience now implemented.
8.	Undertake service review to support service remobilisation and new visiting model.	Complete	See no. 4.
9.	Support Hospital wide Patient Activity Project.	Ongoing	Patient feedback contributed to development of project plan.

8. Challenges, solutions and service development opportunities

Challenges	Solutions / Development Opportunities
Competing priorities as a result of increased workload relating to visiting, impacting on delivery of core function.	Undertake service review following outcome of Visiting SLWG.
'Flat' service workforce structure, need for future proofing in terms of succession planning.	Include within above review to ensure capacity and resilience.
Implementing person-centred visiting, aligned to national guidance. Risks identified as a result of increased use of the Family Centre for visiting.	SLWG commissioned to make recommendations to CMT.
Implementing the new HIS CE QFE self-assessment.	Align existing evidence base to 3 domains which form the QFE: 1. ongoing engagement and patient / care involvement (15 indicators). 2. Involvement of people in service planning, strategy and service design (13 indicators). 3. Governance: Supporting leadership in community engagement (13 indicators).

9. Implications

Staffing
The current staffing establishment of 2 full-time, 2 x 0.5 and 1 x 0.4 WTE has been supplemented to support the current interim visiting arrangements. Following a review of the visiting model, the Corporate Management Team has confirmed that the centralised visiting model will be implemented permanently moving forward.

A proactive approach to ensuring capacity and resilience are in place at service leadership level will be the key focus of the coming six months.

Finance
There are increased costs relating to resourcing of the centralised visiting model however, additional costs relating to the current financial year have been offset by the savings within the Visitor Travel Budget. Funding has been sourced from within the Nursing Directorate to resource a 12-month operational development role to support visiting.

A business case has been approved to fund renovation of the Family Centre garden area from the Capital Budget.

10. Key actions for the next twelve months

	Action
1.	Tailor national 'Interpretation and Translation Policy' for implementation locally.
2.	Develop Carers' Policy.
3.	Complete QI project to increase the number of patients receiving visits.
4.	Develop Action Plans for all Equality Outcomes.
5.	Undertake QI project to increase the number of patients receiving visits.
6.	Support achievement of updated Supporting Healthy Choices Plan.
7.	Implement national Quality Framework for Engagement.
8.	Implement revised Patient Safety Climate Tool.
9.	Adapt EQIA process to incorporate inclusion of updated Fairer Scotland Duty.
10.	Undertake service review to support capacity and resilience at leadership level.
11.	Develop local volunteer drivers' scheme.
12.	Develop Carers' Needs Support Plan.

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Appendix 1 **Patient Partnership Group: Influencing Practice, Improving Experience**

We asked "What would make your shopping experience better?"

You said	We did	The difference it made
"Shopping for clothes and stuff is a nightmare. You need to wait till you	Spoke to patients to understand which websites are the ones most	"It's a good idea and gives me back a bit of control and choice." "I was used

Appendix 2 **The State Hospital Equality Outcomes 2021-25**

Outcome	
1	The outcome of every CPA review process will evidence a collaboratively developed, individually tailored care and treatment plan.
2	Practice, supported by policy, is embedded to ensure that all TSH patients who experience increased emotional distress are cared for adopting a consistent, least-restrictive, person-centred, trauma-informed approach.
3	All patients are supported to participate in a level of physical activity which reciprocates national recommendations, introduced as part of health and wellbeing preventative guidelines.
4	All patients are cared for in ward cohorts which reflect the patient's current stage of recovery, enabling a person-centred model of care which delivers least restrictive practice.
5	TSH will introduce use of digital platforms, enabling patients to communicate safely, effecting reciprocity of access with people who experience mental health issues.
6	Tailored processes, adopting a least restrictive approach are in place to support reciprocity of access to TSH physical environment for all patients.
7	Every member of staff and volunteer will be signposted to and have access to informal, independent, individually tailored Pastoral Support which reflects a holistic approach to wellbeing.

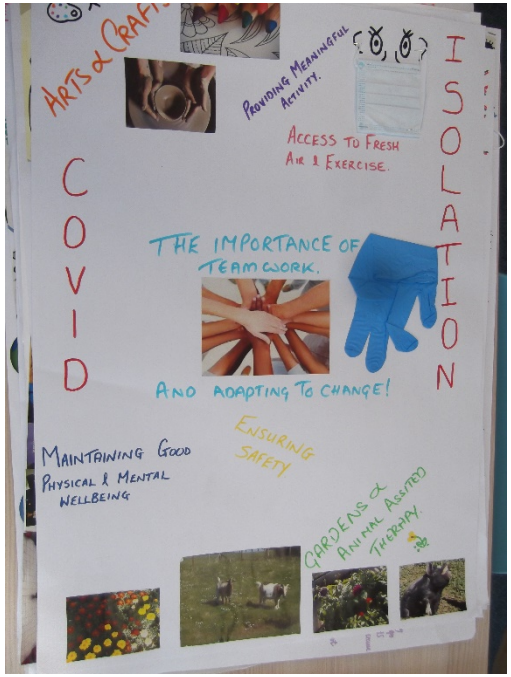
Appendix 3

The State Hospital Initiative 2021: Patient Feedback

Patients across the Hospital engaged in the 'What Matters to You?' initiative focussing on the impact of Covid-19:

Patient Feedback Indicator	Feedback Shared	Posters and Learning
1. **Person Centred Values:** Culture/Faith Dignity and Respect Quality of Life Shared Decision Making	"We were "I needed you to listen to "Staff "Staf f were good at "No haircuts not a "I matter, you matter,	
		• Compassionate care delivery • In response to feedback, equipment was provided for patients to cut their own hair. • Scope to think about how staff can be more easily identified when wearing PPE.

Patient Feedback Indicator	**Feedback Shared**	**Posters and Learning**
2. Effective Communication: Care and Treatment Individual Communication Needs Digital Inclusion "I saw my family every week	"How does anyone think "Everything that I like doing off "We couldn't "Sometimes your head was	 • Value of virtual communication to maintain relationships. • Impact of environmental restrictions. • Lack of spontaneity of contact based on need. • Communication barriers relating to use of facemasks.

Patient Feedback Indicator	Feedback Shared	Posters and Learning
3: **Physical Comfort:** Daily Living Activities Clean and Comfortable Surroundings Health and Wellbeing Safety and Security "Cateri ng staff were "In lockdo wn, the only	"We could have done "Would be good "Covid got "I was worried that if I "You neede d to make "I'm lucky I'm not	 • Acknowledgement of Catering Team's compassionate approach. • Recognition of frustrations of restricted model. • Learning opportunities for patients.

Patient Feedback Indicator	Feedback Shared	Posters and Learning

4: **Emotional Support:**
Peer Support
Clinical
Family / Friends

"I heard staff talking about patients who had Corona

"Covid stopped me

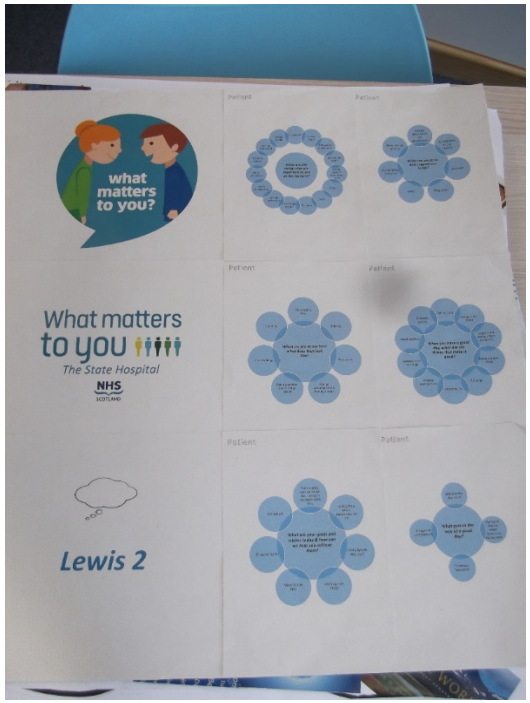
"Why can't my dog come with my mum to

"When we were in lockdown it

"The folk that do

"The choir

"I like to talk to patients who are



- Impact of patients unable to communicate with peers in other wards.
- Importance of relationships.

Patient Feedback Indicator	Feedback Shared	Posters and Learning
5: **Effective Relationships** Meaningful Involvement of Carers Clinical Teams Working Together "They put us into 'bubbles' "I came in when Covid just started. The only "My key worker is the only one who I "Staff may be the "My RMO gets me. I would like her to be around more "Having respect for each other means that	 • Value of shared decision making. • Importance of consistent relationships.

Patient Feedback Indicator	Feedback Shared	Posters and Learning

6: **Access to Care**

"I needed to see the consultant and staff

"I'm not any

"I'm lucky I

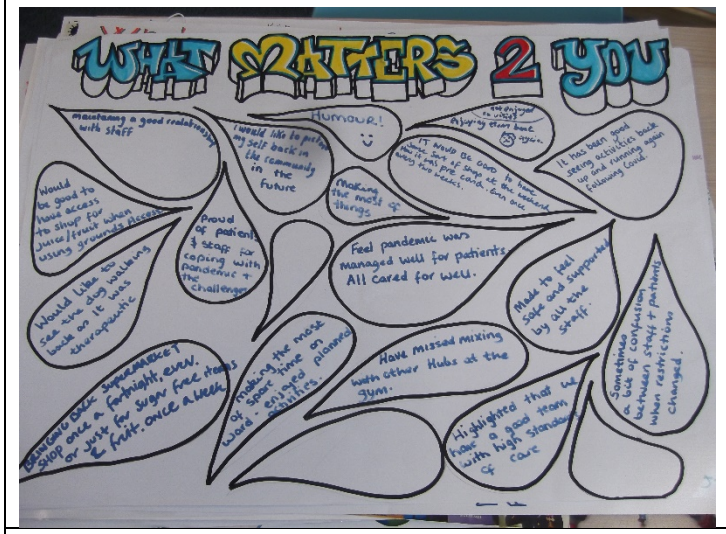
"One of the good

"Covid meant it's taking

"I put

"It was

"No



- Value of structured activity.
- Impact of suspension of some areas of care delivery.

Paper No. 21/93

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	23 December 2021
Agenda Reference:	Item No. 10
Sponsoring Director:	Director of Nursing, AHPs and Operations
Author(s):	Patients' Advocacy Service Manager
Title of Report:	Patient Advocacy Service 12 Monthly Report – August 2020-July 2021
Purpose of Report:	For Noting

1 SITUATION

This report serves to provide assurance to The State Hospitals (TSH) Board that the Patients' Advocacy Service (PAS) continues to meet the needs of State Hospital Patients, as set out in the Service Level Agreement (SLA).

2 BACKGROUND

We will highlight progress made within the service including improvements, achievements, and our future plans. The following report highlights through August 2020-July 2021. As agreed with TSH Board last year, we are now providing 12 monthly update reports to be more in line with the SLA.

3 ASSESSMENT

August 2020 – July 2021

- Retention of staff complement: Service Manager, 2 Part-time Advocates, and 1 Part-time Administrator, ensuring continuity for patients.
- Achievements against the Key Performance Indicators (KPI) in the Service Level Agreement this year continue to be mostly met with statistical reporting evidenced in section 3 and 6; patient narratives in section 7 and accounts in section 11.
- Full and effective use is being made of the budget allocated by the Hospital for the service.

- The additional recurring £20,000 funding received from the Scottish Government following the introduction of the Patients' Rights Bill continues to assist PAS to offer extra support required with hard-to-reach patients and new admissions.
- Robust arrangements are in place for education and support of all Advocates and Volunteer Advocates.
- Positive communication between PAS and The State Hospital continue to foster excellent working relationships beneficial to both organisations.
- This year the amount of actions PAS completed increased compared to the same timeframe the previous year.

Section 9 of the main report identifies both organisational and service developments planned for the next reporting period.

- Continue to recruit Board Members to diversify our Board.
- Update our Board Recruitment processes to be more robust.
- Update our Patient Board Rep recruitment and training package.
- Recruit more volunteers and update our volunteer training package.
- Further expand our knowledge by maintaining current training and continuing to attend relevant courses and webinars.
- Organise the AGM with diversity in speakers.
- Become a completely paper free organisation.
- Continue to explore options to highlight the work of PAS in a wider scope.
- Continue to connect with other advocacy services and share best practice.
- Continue to restructure and streamline our reporting to better highlight the work we complete.
- Remain committed to responding to consultations as appropriate, to champion the voice of our patients in their unique position.
- Complete the annual questionnaire and take forward the views of patients on the PAS service.
- To continue to support The State Hospital in regards to changes in the Clinical Model, ensuring patients' voices are prioritised.
- Review our ward drop in service and how this can better support our patients.
- Continue to stregthen our relationships with both internal and external groups.
- Address issues highlighted regarding patients in seclusion or in very restricted positions.
- Continue to join short life working groups to champion the patient voice.
- Further identify ways for patients to share ongoing feedback on the PAS service.
- Construct a PAS admission booklet for new admissions to TSH.
- Await the Scottish Government reponse to the outcome of the Independent Forensic Mental Health Review with a view to adapating to new ways of delivering Indepent Advocacy within TSH.

4 RECOMMENDATION

The State Hospital's Board for Scotland are asked to **note** this report.

PATIENTS' ADVOCACY SERVICE

12-Monthly Report

1st August 2020 – 31st July 2021

1 INTRODUCTION

The Patients' Advocacy Service (PAS) aims to provide an independent, highly skilled, responsible, and professionally run service within The State Hospital (TSH). Whilst observing the safety and security of the Hospital, the service works independently within it to promote patients as individuals, support them and enable them to be fully informed and involved in their care and treatment.

> *"Independent advocacy is about speaking up for, and standing alongside individuals and groups, and not being influenced by the views of others. Fundamentally it is about everyone having the right to a voice, addressing barriers and imbalances of power, ensuring that an individual's rights are recognised, respected, and secured.*
>
> *Independent advocacy supports people to navigate systems and acts as a catalyst for change in a situation. Independent advocacy can have a preventative role and stop situations from escalating, and it can help individuals and groups being supported to develop the skills, confidence and understanding to advocate for themselves.*
>
> *Independent advocacy is especially important when individuals or groups are not heard, are vulnerable or are discriminated against. This can happen where support networks are limited or if there are barriers to communication. Independent advocacy also enables people to stay engaged with services that are struggling to meet their needs."*

Scottish Independent Advocacy Alliance, Independent Advocacy, Principles, Standards & Code of Best Practice (2019).

The Mental Health (Care and Treatment)(Scotland) Act 2003 establishes the right to access Independent Advocacy for those experiencing a mental disorder. The purpose of this report is to inform and evidence the key performance indicators, stipulated within the Service Level Agreement, by TSH. The report describes how the service provided by PAS has the ability to adapt to the ever-changing needs of the patient population particularly during the pandemic. This includes a focus on the impact on patients, achieved through engagement with the service.

1.1 Highlights of the Year

This report relates to the period August 2020 – July 2021, reflecting on another successful, albeit challenging year, during which we continued to provide an Independent Advocacy service to all patients. Work included this year is as follows.

- Updated the staff recruitment and training schedule which allowed us to successfully recruit both an administrator and advocate and is now more robust.

- Completed the financing and build of a cloud-based system to store all patient and staff information meaning we will be independent from TSH systems.
- Successfully continued to support patients during a pandemic whilst also focusing on the wellbeing of our staff.
- Continued to expand our knowledge by attending training and webinars.
- Started connecting with external organisations and other advocacy services to share experiences and learn better strategies for working in a high secure environment.
- Continued to champion the patient voice by responding to important consultations and highlighting the patients' voice.
- Increased actions and contacts with patients to meet patient needs.

On the 24th of November 2020 PAS held their 11TH Annual General Meeting (AGM) where we delivered our Annual Report for 2019-2020 via Microsoft Teams due to the restrictions in place. Due to these restrictions, our patient group were unable to participate in the meeting. However, one of our patients worked with their advocate to produce a piece for the annual report on the patient experience of covid-19. This was important to ensure the patient group was able to contribute to the report. Additionally, one of our patients graciously offered photographs taken with the art therapist to use for our front cover and designed an art piece to include on our back page (Appendix 1). We wish to formally acknowledge their contributions to the annual report. This was provided to TSH in October 2020.

In February 2021 the Independent Forensic Mental Health Review was published. Throughout the report, there were recommendations made which may impact the delivery of independent advocacy across the forensic mental health estate. Some of the recommendations made which may impact PAS include the provision for high secure services for women in TSH on a short term basis; carers advocacy service to be provided; the provision of collective advocacy; Scottish Government response to the technology and communications report; Information sharing and staff training. As of the end of July 2021 we await response from the Scottish Government and look forward to the challenges ahead and new ways of working.

2 GOVERNANCE ARRANGEMENTS

PAS has dual accountability. Firstly, as an independent company, limited by guarantee to PAS Board of Directors and secondly, as a service commissioned by The State Hospital. We report annually, and in doing so, provide assurance the service meets with the Key Performance Indicators highlighted in the service level agreement. The Person-Centred Improvement Steering Group (PCISG) receives monthly verbal updates by a representative from PAS and the service manager meets separately with the Person-Centred Improvement Lead (PCIL) monthly to provide update and receive support. Additionally, the PCISG receives quarterly written reports highlighting the progress with the set KPI's.

2.1 Finance

The annual cost of the service to the Hospital in the financial year April 2020 - March 2021 was £144,682 which includes recurring funding of £20,000 initially received in April 2012 from the Scottish Government following the introduction of The Patients' Rights (Scotland) Act, 2011.

2.2 Committee Membership and Role

The Board of Directors comprises:

- Michael Timmons, Chair
- Andrew Gardiner, Treasurer
- Heather Baillie, Secretary
- Danny Reilly
- Innis Scott
- Ruth Buchanan

2.4 Board Meeting Frequency

The PAS Board of Directors held 11 Board Meetings during this year and an AGM, all of which took place by video conferencing due to the restrictions in place.

2.5 Workforce

To deliver our KPI's we have a small staff team with a variety of areas of expertise. Our knowledge and experience of engaging with patients continues to expand. This allows us to provide a person-centred service for the patient. Securing and retaining skilled employees is challenging in such a unique environment. Due to the interim posts highlighted in the previous report, we successfully recruited an administrator in September 2020. Following successful interim posts, both the author and interim advocate were offered permanent positions and we were able to offer a permanent post to our administrator. In May 2021, Patricia Davidson, our senior advocate, and volunteer coordinator retired from the service after 14 years working with PAS. This was a great loss to PAS given her experience with the service and we wish her all the best for the future. However, we were successfully able to recruit another full-time advocate in June 2021. PAS aims to offer a senior advocate and volunteer coordinator post, however as this is such a unique setting with a specific set of skills this is something we aim to have in place within the next year.

Currently PAS employs:

- 1 x part-time Manager
- 1 x full-time Advocate
- 2 x part-time Advocates
- 1 x part-time Administrator

With the covid-19 restrictions, we have been unable to resume the volunteer programme as yet. This is something we aim to have in place over the next few months, including an update on the training and recruitment processes.

2.6 Working Relationships

The PAS Manager maintains regular contact with hospital professionals including the PCIL, PCIT, Senior Charge Nurses and complaints officer. This ensures effective communication and collaboration whereby issues are dealt with promptly and locally. In addition, the PAS manager attends other relevant meetings throughout the Hospital and attends each PAS Board meeting to provide a monthly update.

These relationships are vital to the maintenance and amendment of PAS services and will become more crucial given the release of the Independent Forensic Mental Health Review which may cause adjustment to the delivery of independent advocacy in TSH.

2.7 Training

Staff continue to complete and keep updated all mandatory training specified by TSH, including LearnPro modules. PAS welcomes the opportunity to take part in any training and development offered by The State Hospital. This enhances knowledge and skills of our staff group. PAS also strives to offer opportunities to attend training as much as possible including external training such as, through the SIAA and training sourced by PAS independently.

Additional training completed this year:

- Measuring Impact Workshop
- We are a Human Rights Based Organisation
- Impact, Demonstrating the Difference You Make
- GDPR
- Planning in a Crisis
- Introduction to Outlook
- Recruiting, Managing and Supporting Volunteers
- Microsoft Teams
- Retirement Course
- Advance Care and Treatment Planning
- Autism (Forensic Network)
- SIAA – Measuring Impact
- Advance Care and Treatment Planning – End of Life Care
- Sexual Harm, Research, Practice, and Intervention
- Anti-Racism

- Team Member to Team Leader
- Psychiatric Advance Statements
- Victims and Trauma
- Office365 Awareness
- Fused Mental Health and Capacity Legislation
- Ethnic Diversity Matters
- The Triangle of Care – A Professional Perspective – Scottish Mental Health Law Review
- Good Governance
- Learning Disabilities
- How to Build Strong Board Relationships
- The Mental Health Tribunal for Scotland
- Infection, Prevention and Control During the Covid-19 Pandemic
- Forensic Mental Health Review and Special Meeting to Discuss
- Supporting Workforce Mental Health

We actively encourage staff and volunteers to undertake training and continue personal development. This year one of our staff group started undertaking the New to Forensics Course which will give them further knowledge of working with the unique patients within TSH.

2.8 Policies and Procedures

Policies for PAS remains integral to the smooth running of the organisation. Our policies continue to be reviewed when necessary, ensuring they are GDPR and data protection compliant. We continue to increase the number of policies which have been equality impact assessed.

2.9 Participation / Integration

PAS staff participated in several State Hospital groups to facilitate and support integrated ways of working benefitting patient care including:

- Person Centred Improvement Steering Group
- Patient Partnership Group
- Child & Adult Protection Forum
- Complaints and Feedback
- QI Project on CPA's
- Patient Groups via Virtual Platforms

We have also been involved in completing the registered medical officer (RMO) care questionnaires provided to all patients to offer feedback on their designated RMO.

External working groups included:

- Mental Health Tribunal Service Users and Carers Group
- Short Life Working Group – Communications and Specified Persons
- Short Life Working Group – Covid-19 Response and Learning

PAS remains committed to supporting our patient representative to meaningfully engage at our board meetings; the patients' voice is invaluable to the service. This signifies the importance of hearing directly about patients' experiences, to meet the changing needs in the hospital environment and patient group. Following the successful transfer of our previous Board Rep in August 2020, PAS successfully recruited a new patient rep to our board who began attending Board meetings by video conferencing in January 2021.

We are involved in the induction process of new staff, including students and this year have begun offering an induction to student nurses, within TSH. This provides them with a knowledge and understanding of Advocacy and an insight into the role of an Independent Advocate.

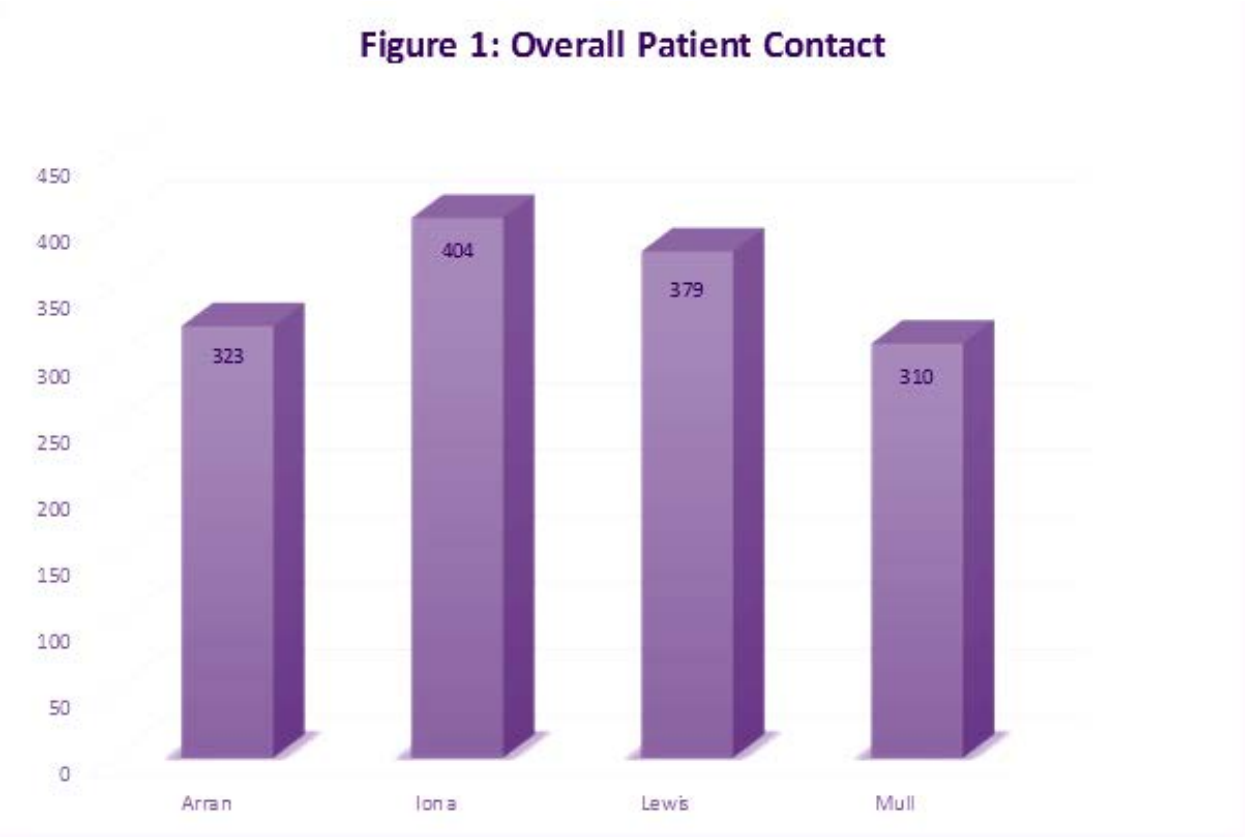
PAS remains involved with the Scottish Independent Advocacy Alliance (SIAA) providing the distinctive perspective of patients within a high secure environment ensuring this is included in any developmental work. We attended the SIAA Annual General Conference and attended several sessions offered by the SIAA including roundtables on the 2021 manifesto, mental health tribunal project and human rights; managers support groups, a training session on measuring impact, and completing a state of the sector survey.

3 KEY PERFORMANCE INDICATORS

3.1 Ward and Skye Centre Contacts

The chart below shows, 149 patients had 1416 contacts during the year; all patients within TSH were seen at least once by an advocate, however most were seen a minimum of twice as we ensure each patient is approached prior to their case review of which they have 2 per year. The average number of contacts per patient throughout the period was 10. These figures include 35 patients transferred to medium secure units, returned to prison, or discharged to the court/community. We also recorded 2 deaths and had 38 admissions during this period.

Figure 1: Overall Patient Contact

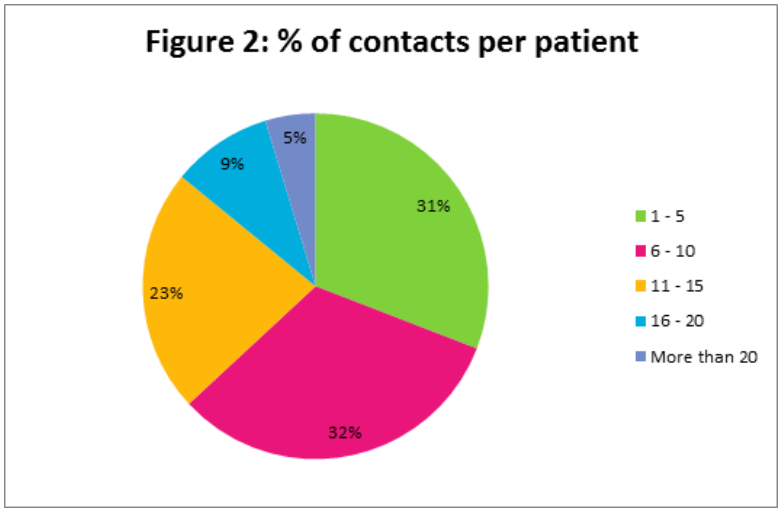


We have already begun to collect information on those with communication difficulties and in future reports will also be including information on those patients who are admissions to the Hospital as well as those identified with an intellectual disability. This will enable us to further break down our contacts and see any trends.

This focus on statistics is vital to showing the work independent advocacy provides and the impact it can have on a patient.

3.2 Contacts per Patient

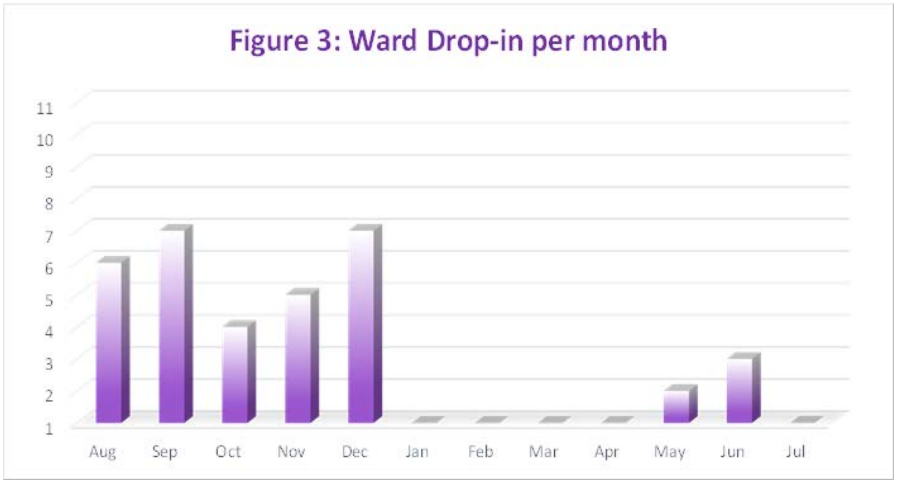
This graph highlights 31% of patients were visited by an advocate between 1-5 times with a further 5% more than 20 times. We continue to monitor patient contacts to ensure these are reflective of the service we provide. Some patients require more support than others, this is particularly true of our intellectual disability patient group and new admissions to the Hospital. On a positive note, the number of patients visited between 1-5 times has reduced by 4% and those more than 20 times has reduced by 5%. This is partly due to better reporting being in place but also highlights a greater equity of advocacy with 63% of patients being visited between 1 and 10 times.



3.3 Attendance on Wards

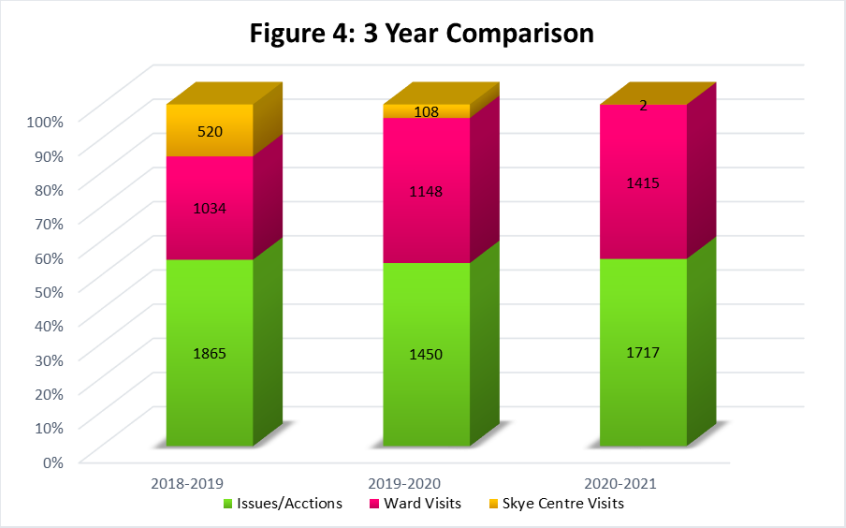
The service level agreement requires PAS to provide a monthly drop-in to each ward. The following graph reflects this target was not met during August 2020-July 2021. This is partly due to lockdown whereby we restricted advocates to the wards to help protect both staff and patients. There was also a period whereby there was reduced staff in the office between January and May 2021. With the retirement of the senior advocate, we also had a month where we did not have a full staff complement which may have had an impact.

The ward drop in model over the years has changed and we have added this as an action point to discuss with Lead Nurses to support more effective use.



3.4 3 Year Comparison (2018-2019, 2019-2020, 2020-2021)

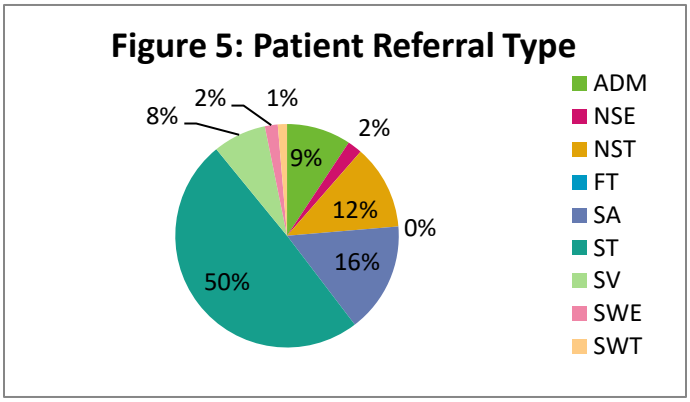
The figures below show a slight increase in contacts and actions performed from the same period the previous year. Some actions which increased over this period were emails, phone calls, gathering information and filling out forms. Some of this can be attributed to increased phone contact with patients and completing legal aid forms when solicitors were unable to attend the Hospital. This ensured patients were continually able to achieve their rights to legal representation and highlights a direct positive outcome of advocacy support. There was a significant drop in the attendance at meetings with solicitor, due to solicitors not being on site and many of the communications between patients and solicitors being done via videoconferencing and phone calls. There also continued to be a drop in the number of contacts in the Skye Centre due to the facility not being open and the restrictions in place. Majority of the other categories were on par with the previous reporting period which is positive given the restriction implications of covid-19. Given the restrictions it is encouraging to see that despite this, we were able to provide input to our patients and respond to their needs.



Although there has been an increase in the number of contacts we had with patients, these were not all face-to-face visits. It should be noted due to our reporting system, ward visits also encompass phone calls with patients.

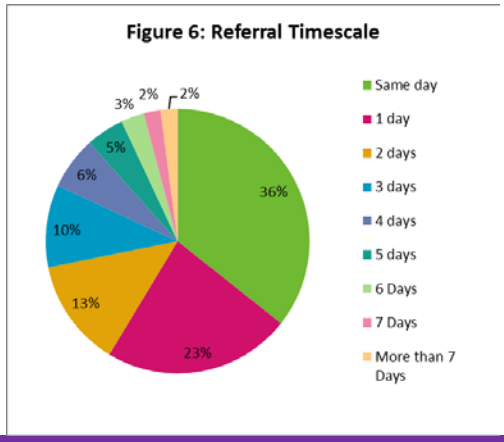
3.5 Formal Referral Routes

These statistics relate to formal requests to see an Advocate, 74% of referrals came from patients themselves via the PAS free phone or via discussion with an advocate. This was an increase of 33%. Hospital staff continue to be vital for us to provide support to patients, with a further 26% of referrals coming from nursing staff and Social Work telephone calls and emails, a reduction of 33% which is positive to see patients are reaching out to advocacy independently. *See Appendix 2 for abbreviations.



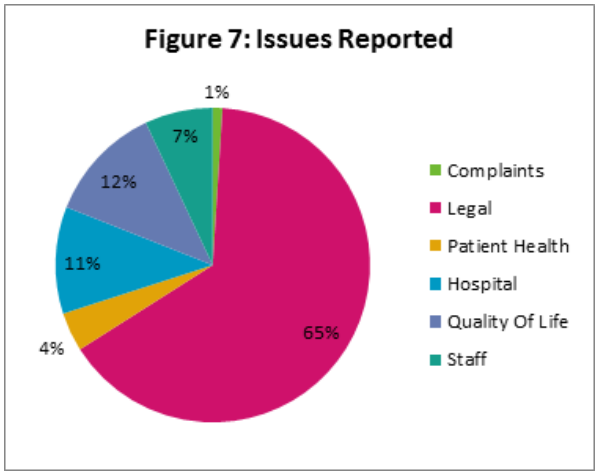
3.6 Patient Referral Timescales

The service level agreement stipulates all patients are seen within 7 working days of referral, but PAS operates to a 5 working day timescale. During this period 2% of patients were seen after the 7 working day period, this is due to advice of nursing staff on a patient's risk which mainly relates to new admissions or because of covid restrictions. A further 67% were seen within 2 working days, which, given the covid restrictions is positive as it continues to show patients have fast access to independent advocacy although it is a slight drop of 2% from the previous report.



3.7 Issues

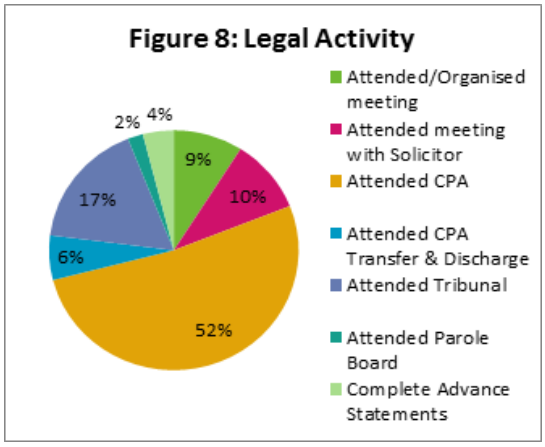
The service dealt with 2381 issues which is an increase from 1912 (469 or 24.5%) in the same period from August 2019 - July 2020; Legal issues remain a majority contributor with 1543 issues (65% of the total). Hospital issues, which cover any hospital-based issue including policies and procedures; ward or hub moves and changes to a patient's clinical team account for a further 11%, a 5% increase from the last report. Lastly, quality of life issues relating to food, family, and grounds access etc account for 12%, a reduction of 6% from the last report.



PAS recorded 19 complaints submitted at stage 1 and 6 resolved locally. 19 discussions of a potential complaint were also recorded. These discussions encompass informing patients of their right to submit a complaint and discussions about the process but which do not get to the stage of a complaint being submitted.

3.8 Legal Activity

Activity classified as legal is associated with support and attendance at formal meetings with patients, such as Care Programme Approach meetings (CPA), Adult Support & Protection Investigation (ASPI), Mental Health Tribunals, Parole Boards and Solicitor meetings with the patient; all of which require support prior, during and following the meeting. We have documented 13 Advance Statements completed with patients within legal activity due to them being a legal document.



4 PROGRESS TO ACTIONS OF THE LAST REPORT

Action	Outcome
Organisational:	
We aim to recruit further Board Members and an additional Patient representative to ensure a variety of expertise and experiences.	Ongoing. We have recruited 2 new board members with unique experiences. We are also continuing to advertise with an aim of diversifying our Board. We also recruited a new patient representative.
Volunteers, we aim to recruit new members to meet the conditions as set out in the SLA.	Ongoing - Training programme updated and given the reduction of covid restrictions, aim to recruit volunteers in the coming months.
We will finalise the staff group to ensure continuity for all.	Complete – All posts were made permanent in February 2021.
Further expand our knowledge by maintaining current training and continuing to attend relevant courses and webinars.	Ongoing – We have attended several training sessions and webinars and continue to attend these when they are available.
Organise the AGM with diversity in speakers.	Ongoing – We held the AGM but unfortunately were unable to secure an external speaker. We hope in the coming years this will be possible.
Service:	
Our impact reporting, this will work in tandem with restructuring our reports.	Ongoing – We have updated our reports significantly from previous years and continue to receive feedback to enhance these. We have also started offering feedback slips and are collecting verbal feedback to greater highlight advocacy impact.
The patient voice, we will continue to respond to consultations as necessary to highlight those marginalised in the forensic mental health system.	Ongoing – We have responded to 2 national consultations this year. We will continue to champion the unique voice of patients in TSH when opportunities present.
The annual patient questionnaire, in conjunction with the PPG we will update to allow greater scope of feedback.	Ongoing – We have held 2 meetings individually with 2 patient representatives. We aim to have this out for patients to complete within the next few months.

Our cloud based system, we will continue to work towards this aim so we can be fully independent from the Hospital and be paper free.	Complete – We have the system built and in operation. The next step will be to transfer all files to the system and start to use. We have started to look at PAS emails to allow us to be completely independent from TSH.
Resuming support of the Hospital and patients in the new clinical model ensuring the patient voice is a priority.	Ongoing – The clinical model has been on pause due to covid restrictions. The PPG has recommenced including Service Change which we have been to attending with a view to supporting patients through the changes with the clinical model in 2022.
Revamp the office space by moving the desks to be covid compliant for when we are able to have more advocates working in the office.	Complete – In October 2020 the office space was moved to create more space and be socially distant.
Our online presence, we will continue to explore how we can be more active online.	Ongoing – We have a twitter page, and a focus of the coming year will be being more active online to highlight the work we do to a wider audience.
The ward drop-in, this will work in tandem with the clinical model to highlight how we can best support the patients.	Ongoing – This was not a priority this year, we have plans to address the drop in model and see how this will fit with the new clinical model.
Our relationships with both internal and external colleagues.	Ongoing – We have excellent relationships with internal staff and continue to seek out opportunities to connect with other advocacy services.
How we work with hard to reach patients and how we can better offer them advocacy support.	Complete – We worked with the PCIL to explore what 'hard to reach' would encompass and it was agreed this would align with those patients who have protected characteristics.

5 AREAS OF GOOD PRACTICE

We continue to maintain good practice and meet requirements of the Service Level Agreement by:

- Review of Policies and Procedures
- Regular support sessions with all staff
- Ongoing staff development and training
- Approachable, unbiased, and visible service

- Positive and professional relationships with stakeholders and other professionals relevant to patients and advocacy
- A variety of expertise within PAS team providing knowledge and experience in a unique setting
- Consistency of staff team ensuring person centred care
- Flexibility to adapt and meet the needs of TSH and patient group

5.1 Progression

Patient contact remains high on our agenda and we are working on how we can involve patients more regularly. We have been working on the patient questionnaire and held 2 meetings with 2 patient representatives to gather their opinions on questions we can ask to gather constructive feedback. This work is ongoing, and we are currently working on the data protection impact assessment with a view to getting this out to patients in the coming months.

Following discussion with a small group of patients, we have also designed and offered feedback slips to all patients. These slips are stored on the ward and have the option for patients to provide ongoing feedback of the PAS service as well as request to see an advocate. So far, these slips have only been in operation for 2 months, we are hopeful in the coming months these will be used more regularly. The feedback received so far can be seen in Section 8.1.

After discussion with the PCIL we considered 'hard to reach' patients and what this definition means. After looking for well-known definitions we were unable to reach a conclusion that would not encompass all patients. As a result, it was agreed we would align 'hard to reach' patients with those who meet the criteria for protected characteristics as defined in the Equality Act (2010). This will allow us to provide statistics on the amount of advocacy input to those of specific categories.

6 OUTCOMES

We continue to work towards producing meaningful outcomes for the Hospital and patients. Reported outcomes centre on Care Programme Approach Meetings (CPA), Mental Health Tribunals and Parole Board hearings. We also support patients through the process of completing advance statements, funeral plans, wills, and complaints.

The tables below reflect the work PAS engages in and the outcomes which follow.

6.1 Care Programme Approach Outcomes

Action	***Patient Outcome***	***Hospital Outcome***	***Total***
Pre-discussion to Admission CPA	Patient supported to understand the process of a CPA, what is involved, who will be in attendance, support to formulate questions and informed of their options regarding attendance.	Patients' rights to independent support upheld. Patients fully informed of the procedure of a CPA saving staff the time of discussing this information.	33
Attendance at admission CPA	Patients fully aware of what is being discussed at the CPA by attending in person or by having advocacy representation on their behalf.	Patient involvement in the CPA process ensuring patient centred care and accessing their rights to independent support in line with the Mental Health Act.	27
Reflective Discussion separate to admission CPA	Supported to fully understand contents of the CPA, the actions to be taken and plans for the next 6 months.	Ensuring patient understanding of the CPA, reaffirming of actions to be taken saving staff time disseminating this information.	15
Declined advocacy support at admission CPA	Having the choice to decline advocacy support following discussion of the admission CPA.	Patients right to independent support upheld and autonomy in decision making.	6
Discussion prior to Annual or Intermediate CPA	Patient supported to prepare for a CPA by discussing the format, formulating questions, writing a statement and deciding on their attendance.	Patient centred care ensuring patient involvement in CPA process.	219
Attendance at Annual or Intermediate CPA	Patient and/or advocacy attendance at the CPA. Ensuring the patient voice is heard and questions answered.	Patient involvement in the CPA process ensuring patient centred care and accessing their rights to independent support in line with the Mental Health Act.	149
Reflective Discussion separate to the Annual or Intermediate CPA	Supported to fully understand the content of the CPA. If not in attendance, ensuring they are aware of discussions and actions to be taken.	Ensuring patient understanding of the CPA, reaffirming of actions to be taken saving staff time disseminating this information.	50
Declined advocacy support at Annual	Patient approached and discussed the CPA process ensuring their right to independent support. Making	Patient rights to independent support upheld and autonomy in decision making.	24

or Intermediate CPA	the choice to decline advocacy support at the meeting.		
Pre-Discussion to Transfer/Discharge CPA	Patient supported to prepare for a CPA by discussing the format, formulating questions, writing a statement and deciding on their attendance.	Patient centred care ensuring patient involvement in CPA process.	22
Attendance at Transfer/Discharge CPA	Patient and/or advocacy attendance at the CPA. Ensuring the patient voice is heard and questions answered.	Patient involvement in the CPA process ensuring patient centred care and accessing their rights to independent support in line with the Mental Health Act.	16
Reflective Discussion separate to Transfer/Discharge CPA	Understanding the content of the CPA and plans for their transfer.	Ensuring patient understanding of the CPA, reaffirming of actions to be taken saving staff time of disseminating this information.	0
Declined Advocacy Attendance at Transfer/Discharge CPA	Patient able to self-advocate and make an autonomous choice to decline support.	Patients right to independent support upheld and autonomy in decision making.	6

6.2 Mental Health Tribunal Outcomes

Action	*Patient Outcome*	*Hospital Outcome*	*Total*
Pre-discussion to Mental Health Tribunal	Patients provided with verbal and written information ensuring they understand their legal rights and the process of the Mental Health Tribunal. Supported to actively write a statement if they wish.	Patients informed and supported with their legal rights i.e., their right to a solicitor and support from Advocacy in line with the Mental Health Act.	117
Attendance at Mental Health Tribunal	Patients supported to attend the mental health tribunal or have their voice heard through advocacy attendance in their absence.	Patients' legal rights to independent support met. Patient involvement in their care.	49
Reflective discussion after the Mental Health Tribunal	Patients supported to understand the outcomes of a tribunal and their legal rights following.	Patient supported to understand their rights and the outcomes saving staff time sharing this information.	6

Declined advocacy support at a Mental Health Tribunal	Able to make an autonomous decision and attend with their solicitor or had no challenges and declined all attendance.	Patient supported to understand their rights and make a choice.	13

6.3 Other Legal Outcomes

Action	*Patient Outcome*	*Hospital Outcome*	*Total*
Advance Statement Completed	Patient's wishes expressed regarding future care and treatment giving a guarantee the clinical team will take these into account.	Fulfilling legal obligation, providing knowledge of Advance Statements and support to complete these. Advance Statements are person centred, considering patient's wishes. Accurately recording and storing Advance Statements with medical records.	11 New 2 Updated 116 Discussions
New Admissions	Patient is informed of the role of Advocacy, their legal rights and how we can support them through their care and treatment.	Legal obligation to provide Advocacy is met as per the Mental Health Act.	38
Supported during a meeting	Patient supported by Advocacy to attend meeting and express their views.	Patients supported as per their right to have Advocacy support as per the Mental Health Act.	22 Meetings 7 Meetings with solicitor
Parole Board	Patients provided information regarding their legal rights and the process of the Parole Board Hearing. Ongoing discussion with patients to ascertain levels of understanding and support accordingly. Statement written and submitted in advance if desired.	Patients informed and supported with their legal rights i.e., their right to a solicitor and support from Advocacy.	30 pre-discussions 4 Reflective Discussions 5 Attended 3 Declined
Adult Support and Protection	ASP referral made when patient feels or is deemed at risk. Advocacy support to attend the meeting.	Hospital fulfilling legal obligation to support patients through ASP process.	7 Discussions 4 Attended

6.4 Other Activity Outcomes

Action	*Patient Outcome*	*Hospital Outcome*	*Total*
Discussion about a complaint	Patient able to express dissatisfaction and discuss their options in line with TSH Policy.	Locally resolved by complaint not being submitted. Patients' rights met.	7
Formal Complaint submitted	Patients' dissatisfaction expressed in line with TSH policy.	Patients' right to make a complaint upheld.	19
Gathered Information	Patient able to access information despite restrictions in accessing the internet. Able to gather information from patient.	Saving staff time by providing the information. Ensuring actively listening to patient and responding accordingly.	420

7 PATIENT STORIES

7.1 Building Relationships

Building relationships with patients is imperative to ensuring patients feel comfortable approaching advocacy with issues. This is particularly true of patients who are less able to engage due to their specific presenting issues, difficulties with mental health or prior trauma. One such patient was difficult to engage in conversation which can be difficult for advocacy staff. However, as resilient people, the advocate working with Mr. A tried to engage. This was a long process and initially consisted of very short conversations often lasting just a few minutes and the advocate engaging in small talk. She made a point of visiting the patient on a weekly basis, continuing to commit and demonstrate to Mr. A he could trust advocacy. It was important to ensure the advocate visited when she said she would to build a strong professional relationship. After several weeks of very short visits Mr. A was able to tolerate interacting with the advocate for longer demonstrated Mr. A was beginning to trust her. As time passed the time Mr. A was able to tolerate advocacy increased and he began to open up more and more at each session. When his CPA came up, he decided he wished to attend the full meeting and agreed advocacy could also attend. Again, it was imperative the advocate stuck to her word and agreed to visit him prior to the CPA to check in with how he was feeling and if he had any questions to answer. On the day of the CPA, the patient expressed he did not want to attend the meeting and did not have any questions to ask. The advocate was able to attend the CPA and feedback what had happened at the meeting and answer any questions he might have. Following the meeting the advocate continued to visit weekly and at this point his engagement was much better than previously. As time went on Mr. A began to make requests of the advocate to contact his RMO with how he was feeling about things such as medication. This was a positive outcome for Mr. A having independent support to voice his views at both his CPA and to his clinical team. Although this could be attributed to various factors, there was no doubt a positive impact from his engagement with advocacy.

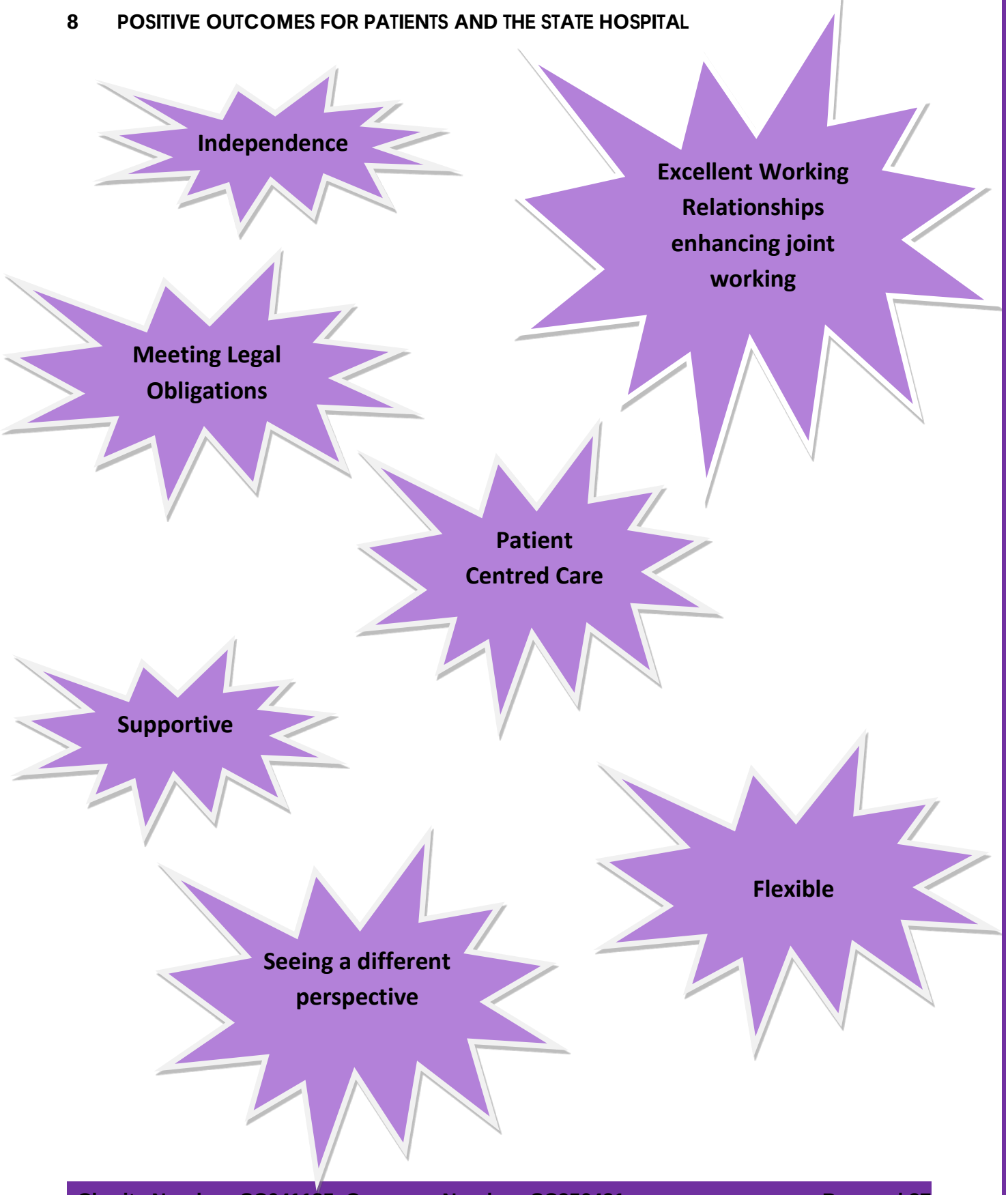
7.2 Access to Legal Representation

When the pandemic hit visitors to the Hospital were no longer allowed to enter due to the restrictions in place. This was also true for solicitors who were regular in visiting patients to enact legal rights. As time went on patients were able to interact with their solicitors by videoconferencing which although a good alternative was different from their regular in person meetings. It also meant solicitors were unable to complete legal aid forms and so advocacy was an important ally in ensuring these could be completed and returned. For those patients who struggle with reading and writing, poor mental health or were generally anxious being faced with long forms, advocacy was able to print out the forms and support patients to complete these. An example of this would be a newer patient, Mr. B who required a mental health solicitor. Although he had a solicitor previously, he wished to work with someone else. Advocacy was able to visit with Mr. B and provide him with a copy of our solicitors list. This is a compiled list of mental health solicitors who have requested to be included on the list and have knowledge of the mental health act amongst other specialties. Mr. B selected 2 solicitors he would be happy to work with, specifying his preference. Unfortunately, his first choice was unable to support him in such a short time frame however his second choice was able to offer advice. Advocacy contacted the solicitor to inform them of the ongoing matter with which he required support. Due to being unable to attend the Hospital, the solicitor requested the legal aid form be completed and returned prior to making contact with Mr.B. Advocacy was able to ensure this form was completed and returned in a timely manner, easing the patient's anxiety and ensuring he had access to legal representation. This was a positive outcome which was directly attributable to the input of independent advocacy and ensured the patient continued to have access to legal representation.

7.3 Acting for Patients Collectively

In July 2021 several patients approached the advocacy service to discuss how the ongoing works in the grounds meant they were regularly unable to access the grounds due to them being restricted. Many patients did not want to take the issue any further but did express their frustrations. As the SIAA states "Independent advocacy supports people to navigate systems and acts as a catalyst for change in a situation", PAS felt it was important TSH were made aware of the frustrations being raised despite patients not wishing to take the situation any further. Unfortunately, these works coincided with placements in the Skye Centre being cancelled and PAS had previously submitted a collective complaint about this issue which was fully upheld. When placements were cancelled, patients felt by also having grounds access restricted or unavailable, they were left with little to do; wards were crowded and there was little opportunity to get away from the ward. As a result, PAS submitted a complaint on behalf of patients expressing how this was impacting them. Whilst waiting for the response to be received, the security department had started to block off specific areas where work was taking place which meant full restrictions were happening less often and weekly communication was being sent out advising of the specific areas unable to be accessed. This meant when placements were cancelled patients were still able to get off the ward and access fresh air. On return, this complaint was partially upheld. Although the changes to communication and specific area's being inaccessible rather than the whole of the grounds is not only because of advocacy submitting a complaint, given the timing of these changes and the partially upheld response it would suggest advocacy were involved in these changes being made. This will have a direct effect on the experiences of patients with available grounds access and those with access to unescorted walks, highlighting the importance of independent advocacy raising issues collectively for patients. It also highlights a positive outcome for TSH by having patients less frustrated and listening to patient concerns.

8 POSITIVE OUTCOMES FOR PATIENTS AND THE STATE HOSPITAL



8.1 Feedback

As highlighted previously, PAS has started to collect feedback from patients in the form of ongoing feedback slips which are available for patients to complete. We would hope the use of these is increased in the coming months and patients will also have the opportunity to provide feedback on whether they wish to continue to have the option to complete these in the upcoming patient questionnaire. The feedback we have received to date both via these feedback slips and verbally is highlighted below.

Date	Comment	Method of collection
02/06/2021	"Maybe you can still be my advocate when I leave so I know what's going on."	Ward Visit
10/06/2021	"Thank you for standing up for me"	After solicitors Meeting
09/06/2021	"Would like to praise all staff that have supported me during my poor mental state. I would also like to thank all PAS for their support too."	Feedback slip
09/06/2021	"Would like to thank the PAS team for doing a good job in supporting all patients."	Feedback Slip
08/07/2021	"I would like to thank you both for the caring support that you have given me. I don't know what I would have done over these last few weeks."	Thank you, card
13/07/2021	Thanked for my support, 'Thank you I'm really grateful' and thanked for seeing afterwards.	Verbal following CPA

9 FUTURE AREAS OF WORK AND SERVICE DEVELOPMENTS

9.1 Organisational

PAS remains committed to providing the highest quality advocacy service to TSH patients. We continue to develop the service to meet the needs of the changeable patient group and the changing environment we work in. As an organisation we aim to develop in the following areas:

- Continue to recruit Board Members to diversify our Board.
- Update our Board Recruitment processes to be more robust.
- Update our Patient Board Rep recruitment and training package.
- Recruit more volunteers and update our volunteer training package.
- Further expand our knowledge by maintaining current training and continuing to attend relevant courses and webinars.
- Organise the AGM with diversity in speakers.
- Become a completely paper free organisation.
- Continue to explore options to highlight the work of PAS in a wider scope.
- Continue to connect with other advocacy services and share best practice.

9.2 Service

As a service we continue to look at ways to improve in the following areas:

- Restructure and streamline our reporting to better highlight the work we complete.
- Responding to consultations as appropriate, to champion the voice of our patients in their unique position.
- Complete the annual questionnaire and take forward the views of patients on the PAS service.
- Support TSH in regards to changes in the Clinical Model, ensuring patients' voices are prioritised.
- Review our ward drop in service and how this can better support our patients.
- Stregthen our relationships with both internal and external groups.
- Address issues highlighted regarding patients in seclusion or in very restricted positions.
- Join short life working groups to champion the patient voice.
- Further identify ways for patients to share ongoing feedback on the PAS service.
- Construct an admission booklet for new admissions to TSH detailing the role of advocacy and the support we can provide.
- Await feedback from the Scottish Government on the Independent Forensic Mental Health Review and how we can amend PAS in light of these outcomes.

10 Ethnicity Group Contacts for all Patients, 1st April 2020 – 31st March 2021

This table demonstrates PAS provides support to patients from a variety of ethnic backgrounds equally and continually monitors this.

Ethnic Group	PAS Code	No. of Patients	Percentage	No. of Contacts	Percentage
White Scottish	1A	90	60%	819	57.8%
White Other	1B	8	5.35%	85	6%
White Irish	1C	1	0.67%	11	0.77%
White English	1D	5	3.4%	36	2.57%
Other Ethnic Background	1E	1	0.67%	6	0.42%
White British	2A	37	25%	375	26.48%
Asian, Asian Scottish, Asian British	3B	1	0.67%	31	2.18%
African, African Scottish, African British	4B	1	0.67%	14	0.98%
Other Ethnic Groups, Chinese	3E	1	0.67%	17	1.2%
Unknown		4	2.9%	22	1.6%
	Total	149	100%	1416	100%

11 FINANCIAL REPORT

Income and Expenditure Report

For the period from 1 April 2020 to 31 March 2021

	£
Gross Income	144,682
Gross Expenditure	149,247
Incoming Resources	
Government Funding	144,682
Bank Interest	0
	144,682
Cost of Charitable Activities	
Employment Costs	142,658
Expenses	470
Establishment Costs	1,583
Print, Post, Stationery	0
Subscriptions and donations	380
	145,091
Governance Costs	
Accountancy Fees	2,274
Professional Fees	1,432
	3,706
Total Resources Expended as per Account	**148,797**
Cash & Bank Accounts	**46,164**
Liabilities payable in one Year	5,062
Net Current Assets	**41,102**

12 NEXT REVIEW DATE

The Patients' Advocacy Service Annual Report will be available to The State Hospital Board from August 2021.

13 REFERENCE LIST

Equalities Act (2010), [Online], Available at https://www.legislation.gov.uk/ukpga/2010/15/contents

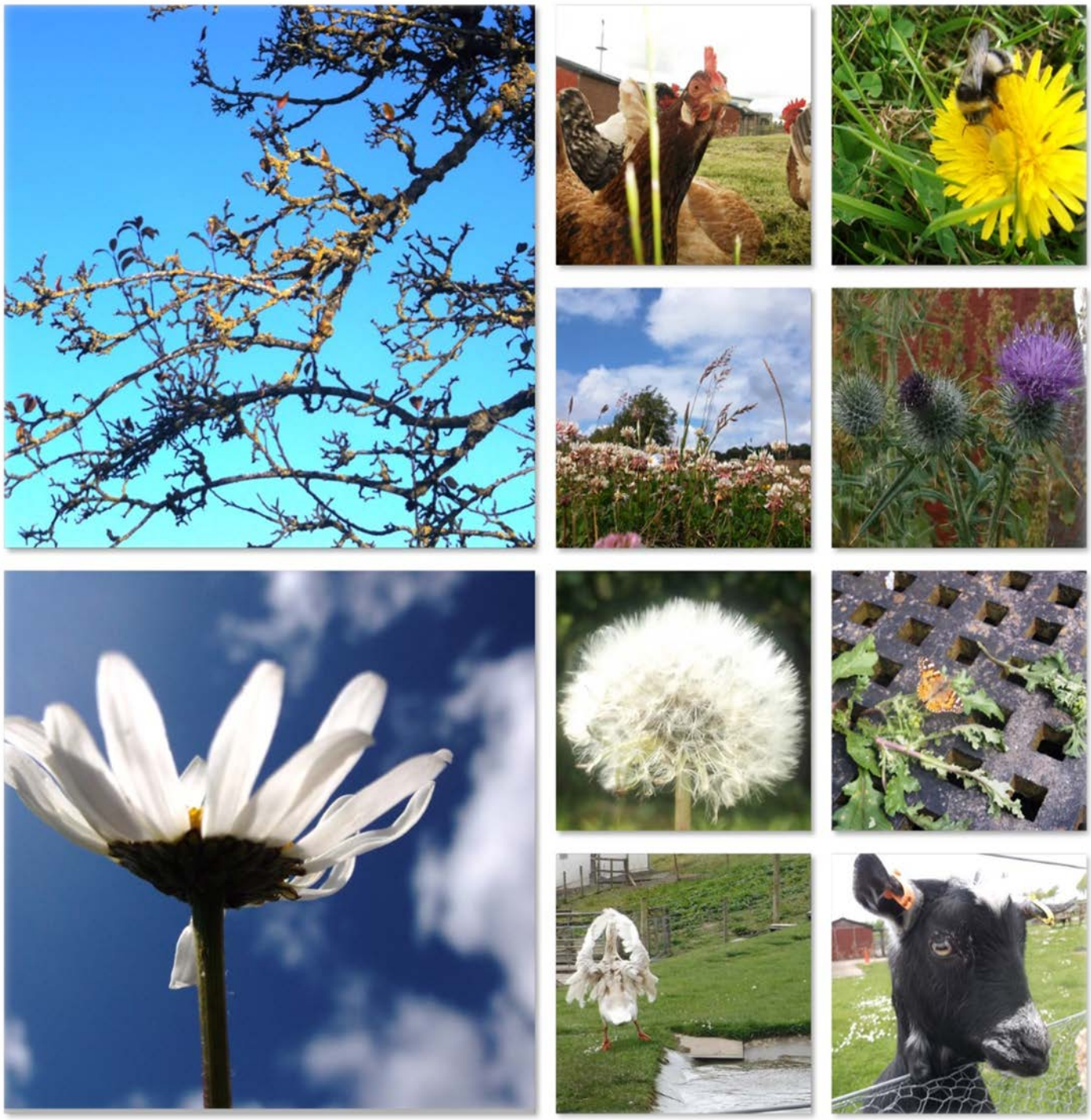
Scottish Independent Advocacy Alliance (2019), Independent Advocacy, Principles, Standards & Code of Best Practice. [Online], Available at https://www.siaa.org.uk/wp-content/uploads/2019/10/SIAA_Principles_Standards_Best_Practice_report_2019.pdf

The Patients Rights (Scotland) Act (2011), [Online], Available at https://www2.gov.scot/Topics/Health/Policy/Patients-Rights

The Mental Health (Care and Treatment)(Scotland) Act (2003), [Online], Available at http://www.legislation.gov.uk/asp/2003/13/contents

14 APPENDIX 1

Photos provided for the front cover of the annual report.



Drawing provided for the back cover of annual report.

15 APPENDIX 2

Abbreviations for Figure 5	
ADM	Admission
NSE	Nursing Staff Email
NST	Nursing Staff Telephone
SA	Self-Answering Machine
ST	Self-Telephone
SV	Self-Verbal
SWE	Social Work Email
SWT	Social Work Telephone

Paper No. 21/94

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	23 December 2021
Agenda Reference:	Item No: 11
Sponsoring Director:	Medical Director
Author(s):	Head of Corporate Planning and Business Support
	Head of Clinical Quality
Title of Report:	Quality Assurance and Quality Improvement
Purpose of Report:	For Noting

1 SITUATION

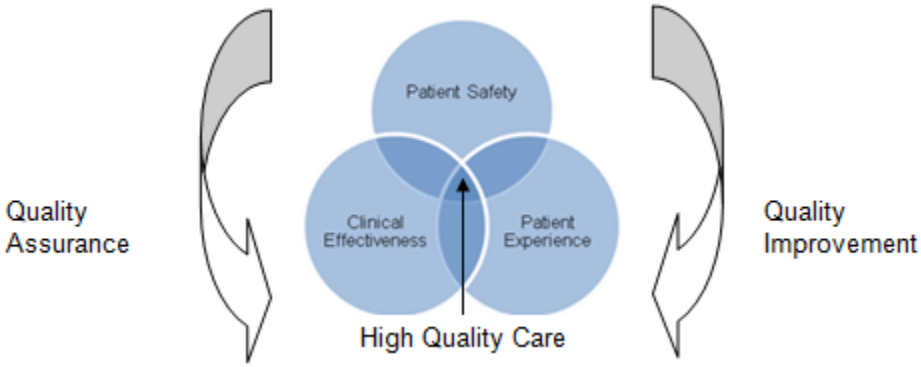
This report provides an update to The State Hospital Board on the progress made towards quality assurance and improvement activities since the last Board meeting in October 2021. The report highlights activities in relation to QA and QI and outlines how these relate to strategic planning and organisational learning and development. It contributes to the strategic intention of The State Hospital to embed quality assurance and improvement as part of how care and services are planned and delivered

2 BACKGROUND

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

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

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



3 ASSESSMENT

The paper outlines key areas of activity in relation to:

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

4 RECOMMENDATION

The Board are asked to note the content of this paper

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

	□ There are privacy implications, full DPIA included.

ASSURANCE OF QUALITY

Clinical Audit

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

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

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

Post Physical Intervention Audit

Areas Showing Improvement

- For 13 (93%) occasions where secure holds were recorded, there were Post Physical Intervention Assessment (PPIA) forms completed by Senior Clinical Cover on RiO
- Of the 13 completed PPIA forms 12 (92%) had been closed off in RiO
- For the 14 occasions on Datix where physical interventions took place there were 2 (14%) occasions where injuries were recorded, both (100%) of which had a corresponding PPIA form completed.
- On these 2 PPIA forms, the information matched with the injury site details recorded on Datix on both (100%) occasions

Areas for Improvement

- The incident time on the PPIA form did not always match with the incident time recorded in Datix. This can cause confusion if the patient has been restrained on more than one occasion that day. The largest difference in time was 6 hours and 12 minutes. This has been highlighted to the teams through the report and displaying of the poster within the wards.
- There continues to be challenges with the completion of the NEWS when a patient has been taken to the floor in secure holds. RiO 21 has a module that should help with this. A business case is being submitted for the purchase of this module.

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

Observation Level Audit

Areas showing improvement

- For the 23 patients that were placed on Level 2 Observations, 96% of patients had evidence of review discussions taking place. If only the policy directives were audited there would be no gap in supporting evidence. This is the first time target has been achieved in this area.
- For the 9 patients on level 3 observations, 100% of patients had evidence found within the note types of review discussions taking place.
- For the 9 patients on level 3 observations Nursing progress notes were reviewed to find evidence that observation level review discussions had taken place between nursing and medical staff. Evidence was found on 89% of occasions, this is an increase from 75%. If only the policy were audited there would be

a negative difference in data of 44%, this is a reduction in a gap in evidence from 44% and 25% in the previous 2 audit periods.

- Of 9 RMO's that had patients on increased observation levels there is a requirement for 4 of them to use the note type for level 3 patients. This was carried out by all 4 (100%) of the relevant RMO's to varying degrees.
- For the 7 patients who had been on Level 3 observations for longer than 28 days, 6 (86%) had a minimum of 1 Appendix 4 form available within RiO. This has maintained from the previous audit.
- From an expected submission of 22 Appendix 4 forms, 18 (82%) were available within RiO. This is a continued reduction in availability from 85% and 84% in previous audits.
- The observation section of the CTM Form was completed on 103 (98%) occasions.
- The observation section of the CTM Form was left blank on 3 (2%) occasions; target is 0%. This is a noted improvement from 15% in the previous audit.

Areas for Improvement
There were 2 areas for improvement. But it should be noted that both these areas have shown improvement since the last audit cycle.

- For the 9 patients on level 3 observations Medical progress notes were reviewed to find evidence that observation level review discussions had taken place between nursing and medical staff. Evidence was found on 78% of occasions, this is an increase from 50%.
- Of the 147 occasions where Nursing used the observation review note type, 61% of its use was to record discussions which included the RMO. This is an increase in use from 54% in the previous audit period.

A discussion point from the observation level audit was taken to the Patient Safety Group to discuss whether patients who go between seclusion and level 3 observations for more than 28 days should trigger an appendix 4 review. It was agreed that due to the restrictive nature of both these practices that an appendix 4 review would be beneficial. An amendment will be made to the policy to reflect this going forward.

Record Keeping Audit

Unvalidated entries
Over the full month of September there were only 22 entries invalidated within RiO. This continues to be excellent compliance with the standards and a significant improvement from baseline when we were seeing 561 unvalidated entries.

Scanned documents placed in the correct patient's electronic record (last 10 for each patient)
We are seeing excellent compliance with this with September's data showing 97% compliance.

Nursing Entry on Every Shift
We are seeing excellent compliance with this with September's data showing 99% compliance

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

Clinical Governance Committee
At the meeting on 11th November 2021 the following papers were presented with a number of quality assurance and improvement activities contained within them:

- Covid 19 Update
- Physical Health Steering Group 12 monthly report

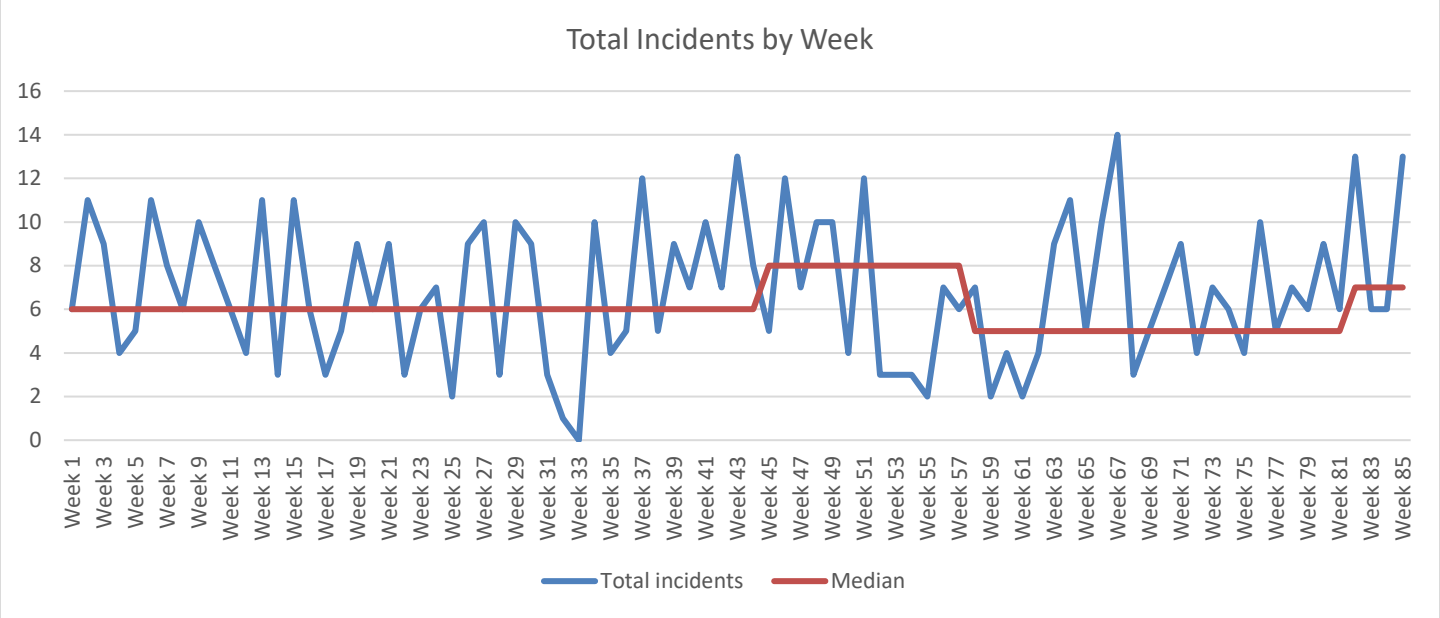
- Patient Movement Statistical Report
- CPA/MAPPA 12 monthly report
- Adult and Child Protection 12 monthly report
- Rehabilitation Therapies 12 monthly report
- Duty of Candour 12 monthly report
- Staffing and Care Report
- Learning from Feedback Quarterly Report
- Learning from Complaints Quarterly 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

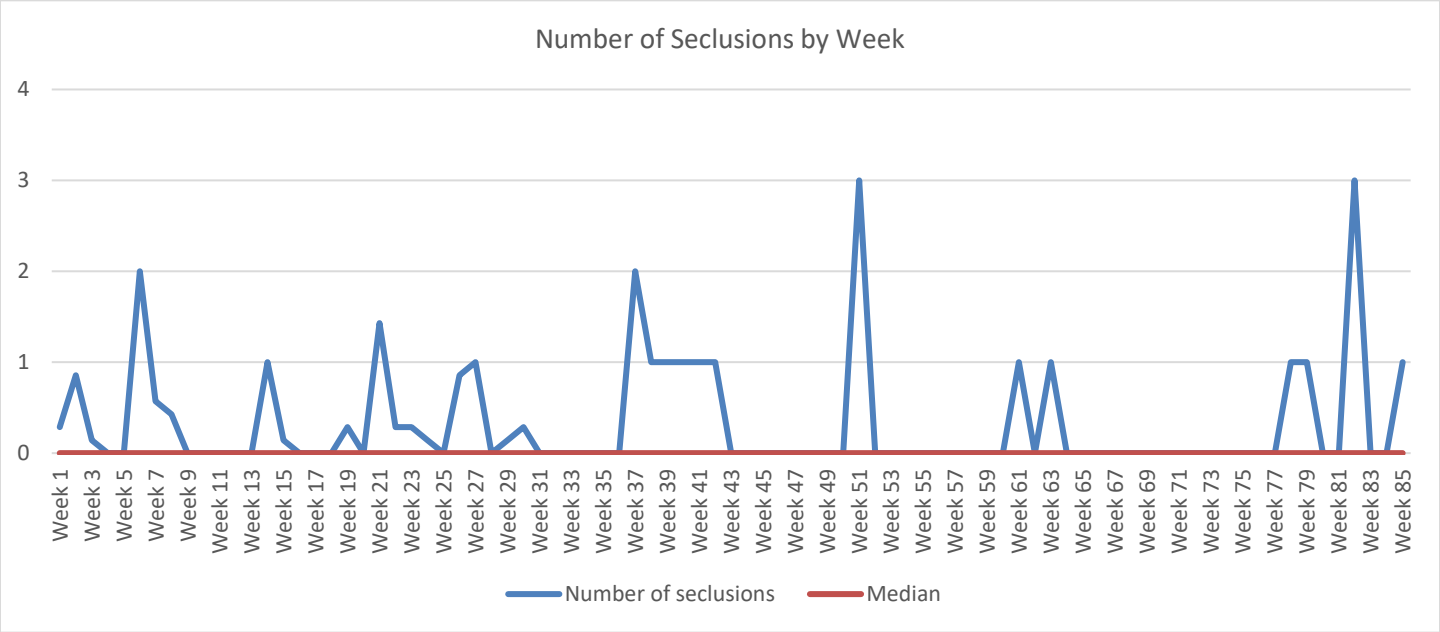
Clinical Quality continue to collate and present the data that gives the Corporate Management Team the assurance that it is safe to continue with the Interim Operational Policy. A sample of the most recent data is below. The full report can be provided on request:

Datix assaults, attempted assaults and behaviour
Although the median increased from 5 to 7 in week 81 the increases in incidents is predominantly due to 2 patients that have been particularly unwell in the last month.



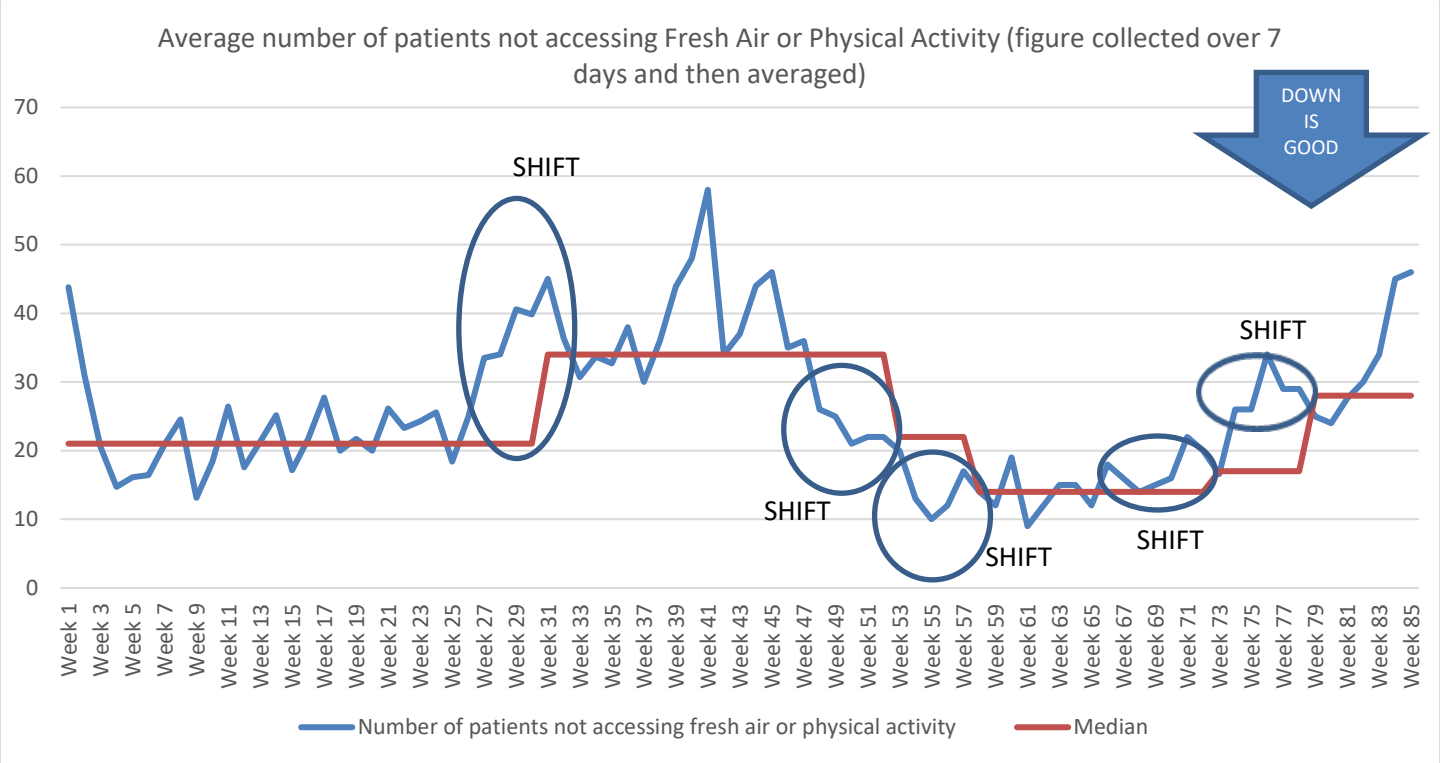
Seclusions

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 82 saw the number of seclusions increase to 3, however this was 2 patients with one patient being secluded twice within the 7 day period..



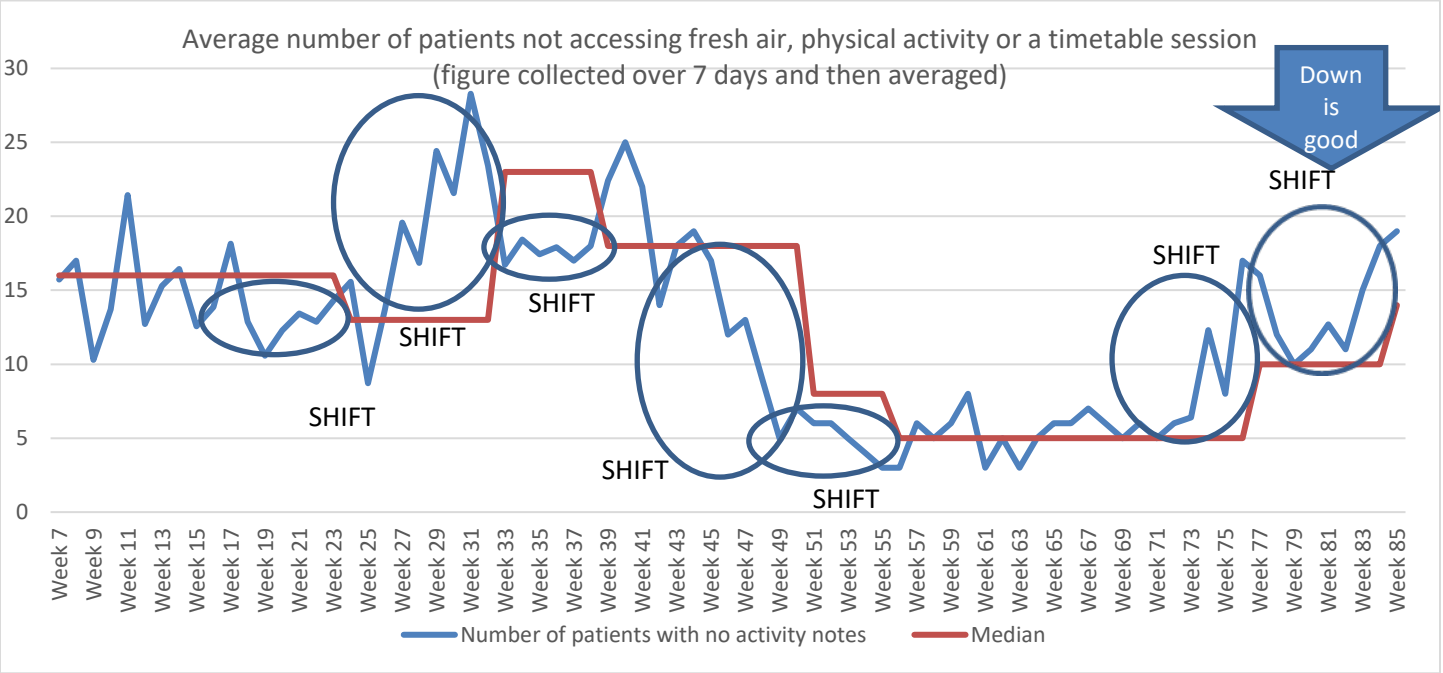
Patients not accessing Fresh air or Physical Activity (this is an average daily figure)
This indicator looks at both the fresh air data from PMTS and timetables and the physical activity data from RiO and highlights the patients that have had no fresh air or physical activity.

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, the latest negative shift was seen between week 77 and 85 (24th September and 18th November). The shift came at a time when we were starting to see inclement weather, challenges with ward staff shortages, an increase in the additional staff required to support patients on level 3 observations and patients and wards being isolated due to positive covid results.

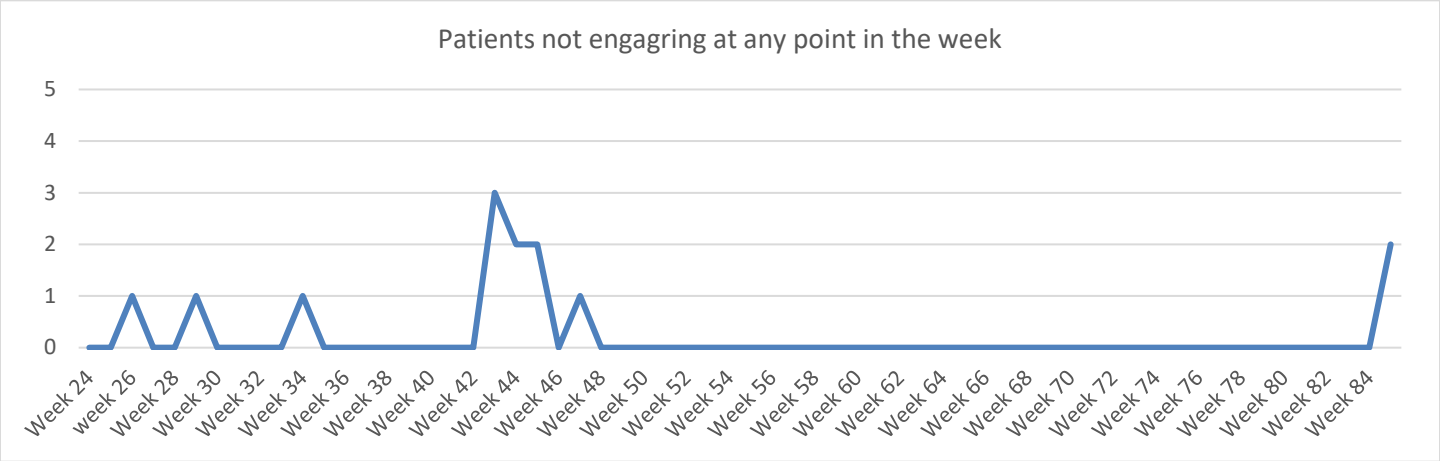


As can be seen below we can see correlation between the wards having to isolate and the negative shifts in the fresh air, physical activity and timetables data:

Ward Isolating	Isolation Dates	Week Number on Chart
Mull 1	31st August – 14th September	Week 74 -76
Iona 3	3rd September – 28th September	Week 75 – 78
Lewis 1	11th October – 28th October	Week 80 – 82
Mull 2	5th November to 19th November	Week 84 – 85
Lewis 2	7th November to 21st November	Week 84 – 85
Iona 2	18th November to 12th December	Week 85 - current

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 had engaged with some form of activity at some point in the week since week 48. In week 85 however we had 2 patients that did not engage at any point in the week. Both these patients were in isolation due to testing positive for covid.



The Operating Model Monitoring Group have commissioned 2 further reports in November in response to the data. The first is a weekly report from the Skye Centre to give context to the data and also a report that shows the activities patients have had on the days their wards have been closed – this is to see variation across the site and good practice that can be shared. The table below is taken from the week 85 report.

Date	Ward Closed	Impact on Patients
12/11/2021	Lewis 1	12 out of 12 patients had at least 1 activity
13/11/2021	Iona 3	9 out of 12 patients had at least 1 activity
14/11/2021	Arran 1	12 out of 12 patients had at least 1 activity
14/11/2021	Iona 1	6 out of 11 patients had at least 1 activity
15/11/2021	Arran 1	10 out of 12 patients had at least 1 activity
15/11/2021	Iona 3	10 out of 12 patients had at least 1 activity
15/11/2021	Lewis 3	11 out of 12 patients had at least 1 activity
18/11/2021	Iona 1	9 out of 12 patients had at least 1 activity

QUALITY IMPROVEMENT

QI Forum

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

The QI Forum carried out a review of its purpose and function, this included a development session in November to refresh and build momentum and provide focus and clarity for the future direction over the next 12 – 18 months. The review recognized achievements made in raising the profile of QI, support available and capacity building. It also recognized the constraints of time available for QI on top of other commitments. The QI Forum agreed a range of actions and priorities to guide strategic development and embed QI approaches across TSH.

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 Scottish Government were provided with an interim update at end October where detailed progress to date against our action plan was presented. The recently appointed RM and SPSP Project Manager has met with relevant groups and individuals as part of induction. Future plans, which have been agreed with Scottish Government, include the development of an updated action plan. This will be submitted end of March 2022.

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 to 31 October 2021, 22 guidance documents have been reviewed. Three were recorded for information and awareness purposes and 4 are currently awaiting review by their allocated steering group for decision as to the need for an Evaluation Matrix – these were for the following:

TABLE 1 EVIDENCE REVIEWS

Body	Title	Steering Group
Scottish Government	Guidance on the storage of medicines (including Controlled Drugs) in clinical areas	Medicines Committee
Mental Welfare Commission	Scope and limitations on the use of Section 47 of the Adults with Incapacity Act	Mental Health Practice Steering Group
Mental Welfare Commission	Preparation of care plans for people subject to compulsory care and treatment	Medical Advisory Committee
NICE	Chronic fatigue syndrome – diagnosis and management	Physical Health Steering Group

The remaining 15 documents were considered to be either 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
Scottish Government	1	0	1 (as above)
Mental Welfare Commission	4	2	2 (as above)

Healthcare Improvement Scotland (HIS)	2	1	0
National Institute for Health & Care Excellence (NICE)	15	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. A date is currently being sought for a PHSG sub group to review and complete an evaluation matrix. 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. A date is currently being sought in order to complete an evaluation matrix for the remaining Kings Fund document entitled Courage of Compassion.

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	Date being arranged for sub-group to complete evaluation matrix.	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

The Kings Fund	Courage of compassion – Supporting nurses and midwives to deliver high quality care	HR and Wellbeing Group	CQ requested to assist in review of document in October 2021. Date being arranged for sub-group to complete evaluation matrix.	September 2020

THE STATE HOSPITALS BOARD FOR SCOTLAND

Minutes of the Clinical Governance Committee Meeting held on Thursday 12 August 2021 at 9.45am via MS Teams CG(M)21/03

CHAIR:

Non Executive Director	Cathy Fallon

PRESENT:

Non Executive Director	Stuart Currie
Non Executive Director	David McConnell
Non Executive Director	Brian Moore

IN ATTENDANCE:

Head of Risk Management	Allan Hardie
Chief Executive	Gary Jenkins
Consultant Forensic Psychiatrist	Khuram Khan
Head of Psychology	John Marshall
PA to Medical & Associate Medical Directors	Jacqueline McDade
Head of Corporate Planning and Business Support	Monica Merson
Director of Nursing, AHPs and Operations	Mark Richards
Board Secretary	Margaret Smith
Medical Director	Lindsay Thomson

1 APOLOGIES AND INTRODUCTORY REMARKS

Cathy Fallon welcomed those present to the meeting. Apologies for absence were noted from Robin McNaught and Sheila Smith.

2 CONFLICTS OF INTEREST

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

3 TO APPROVE THE MINUTES / ACTON NOTE OF PREVIOUS MEETING HELD ON 6 MAY 2021

The Minutes of the previous meeting held on 6 May 2021 were amended as follows:

on page 4, second paragraph, to read “Derek Barron” and

page 10 fifth paragraph, second sentence, to read “Gary Jenkins advised that he had a similar situation in his previous job that was for a driving post and he will obtain further information and this will be sent via e-mail to Brian Moore and Cathy Fallon”.

The minutes were subsequently approved as an accurate record.

4 PROGRESS ON ACTION NOTES

Supporting Healthy Choices

Lindsay Thomson advised that, although a paper was included for today’s meeting, an update will be going to the next Board meeting, therefore, will not be discussed at this time.

Safe Staffing

On agenda for discussion.

5 MATTERS ARISING

There were no matters arising at this time.

6 RISK REGISTER

The Committee received and noted the Corporate Risk Register report (clinical), presented by Allan Hardy, Head of Risk Management.

It was noted that, following discussion at Corporate Management Team, staffing resources had moved to high risk and Covid had been downgraded from very high risk to high risk.

The Committee noted the Corporate Risk Register report (clinical).

7 PATIENT SAFETY 12 MONTHLY REPORT

The Committee received and noted the Patient Safety 12 monthly report, presented by Mark Richards, Director of Nursing, AHP and Operations. The report provides an update relating to the period July 2020 – June 2021, in respect of progress with all 4 safety work streams; a change in practice with the PMVA policies now included under the remit of the Patient Safety Group; comparison with last year's planned QA/QI activity; an update on the driver diagrams that have been received from the National Patient Safety Team and the challenges that patient safety at The State Hospital is currently experiencing.

Mark Richards highlighted the planned activity for the coming year:

- Populating a plan of work based on the safe essentials of care driver diagrams
- Exploring what the leadership walkrounds should look like in their new format and commence these
- Ensuring the PMVA policies are reviewed and audited, with improvement plans agreed and implemented as required
- Exploring the refreshed Scottish Safety Climate Tools for staff and patients to ascertain if the patient one can be adapted for our patients.

Mark Richards advised that we have recruited a part time programme manager who will work between patient safety and realistic medicine.

David McConnell asked what the leadership walkrounds will look like and if non-Executive Directors would be involved.

Mark Richards advised that they are keen to engage with non-Executive Directors and will write to Margaret Smith to seek nominations for non-Executive Directors to be involved in that work. The group are keen to refresh the approach to walkrounds and are looking at methodology used in other parts of the UK, one of which is a 15 steps approach which is taking 15 steps into a ward, pausing and assessing what you see.

Brian Moore asked for more information on the clinical pause and if improvements with regards to observations aligns with some of the internal audit work on this.

Mark Richards advised that the clinical pause was introduced in the State Hospital 3 or 4 years ago, led by Dr Gordon Skilling, for clinical teams to pause when there have been issues that have been particularly challenging; these are used regularly and work well for us; these are embedded into practice in each ward. With regards to audit findings, as part

of the work to reposition our observation practice with the improved observation practice policy, the audit will address issues that are recorded within the patient recording system.

The Committee noted the patient safety 12 monthly report.

8 FORENSIC MEDIUM AND HIGH SECURE CARE ACTION PLAN

The Committee received and noted the Forensic Medium and High Secure Care Standards Action Plan, presented by Lindsay Thomson, Medical Director.

Lindsay Thomson advised the Committee that the State Hospital participates in the National Quality Improvement Framework and are measured against high secure standards by our own completion of the paperwork and by peer review visits, from which an action plan is created. Of the 37 actions assigned, 2 remain outstanding; one is the clinical model and the other is communication and digital inclusion, work on which is well under way.

Brian Moore advised that as the majority of recommendations have been completed, there is no need to keep this on the Committee workplan.

Lindsay Thomson advised that work on the third round of the continuous quality improvement framework should have commenced in April 2020 and the first step in the process is to get people together across the network; this has been put on hold due to Covid as many health boards are not allowing staff to engage in that type of work. Standards need to be created followed by a round of data collection and peer review visits. High secure will not be a priority in the next round it will be medium, low and community and then high secure will be last.

Cathy Fallon advised that, going forward, this work will be monitored by the Clinical Governance Group, the minutes from which can be shared with the Committee. This item can, therefore, be removed from the workplan going forward.

The Committee noted the updated action plan.

9 STAFFING AND CARE REPORT

The Committee **received** and **noted** the Staffing and Care Report, previously reported as Safe Staffing Report.

Margaret Smith advised that this report involves 2 different elements of reporting, the first is staffing levels and delivery of care in the hospital which Mark Richards will pick up on and that the report will now be renamed staffing and care report; this will continue to provide assurance on the delivery of safe and effective patient care within The State Hospital and will report to the Clinical Governance Committee. The second element is reporting on preparedness for the implementation of the Health and Care (Staffing) (Scotland) Act 2019 which, although not expected immediately, is on the horizon and this element will be fed through the Staff Governance Committee.

The Clinical Governance Committee noted the plan for reporting to the two committees and were content with this process. They also supported the renaming of the report, which will be reflected in the workplan.

Mark Richards advised that the report covers nursing staff and confirmed that the risk grading for this staff group has been re-graded as high. The report covers the period from April to June 2021

There are a number of factors affecting the delivery of adequate staffing levels such as sickness absence, vacancies and health restrictions/unplanned leave. This report details this along with the current staff in post.

The funded establishment for the wards totals 292 whole time equivalent (wte) staff. The current staff in post is 272.6 wte.

66 incidents were recorded during this period, showing an increase of 47 on the previous quarter. In the last quarter staff incidents have increased from 9 in April, 14 in May to 43 in June. This a similar pattern we are seeing in the incident reporting overall as well as in a small scale in some of the other categories. On all occasions, appropriate modifications were made to care delivery.

There was one occasion when business continuity measures required to be put in place when Lewis 1 was closed on 31 May 2021 during a shift, with patients kept behind locked doors.

Recruitment is underway with 7 staff due to start with us, 3 are staff nurses and 4 are nursing assistants working towards registration. Following graduation in October, we have a further 9 staff expected to start. Mark Richards highlighted to the Committee that all boards are competing for staff at the moment.

Stuart Currie asked what mutual aid means in terms of the State Hospital. Mark Richards advised that we have provided mutual aid to other services during Covid (a care home within NHS Grampian) but we have not brought this in to the State Hospital due to specific induction required to work in this environment.

Mark Richards advised that work is being done in partnership to look at how we are making best use of shift patterns and supplementary staffing to ensure safe staffing levels.

David McConnell asked how imminent the retirement of 11 staff is. Mark Richards advised that these staff have indicated retirement between now and the end of the financial year and that other boards are facing a similar situation as staff are choosing to retire before the pension reform kicks in at the end of March 2022.

Gary Jenkins advised that discussions are taking place to discuss supplementary staffing and a nurse bank within the Hospital.

The Committee noted the report.

10 COVID-19 REPORT

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

Lindsay Thomson advised that during the last quarter there had been no new patient infections with Covid-19 and the clinical model returned to business as usual, with the exception of staff wearing masks, in June 2021. She suggested that this may be an ideal time to consider what the Committee would like in terms of ongoing reporting.

Routemap
First Minister statement from 2 August with exception of masks, restrictions were largely removed on 9 August. In terms of test and protect, the main announcement from the Scottish Government to us is that if we are “pinged” but double vaccinated and 10 days post second vaccine and have a negative PCR, we can return to work but this is on a voluntary basis.

Infection Control
Tom Gillespie and Karen Burnett provide advice. National guidance is issued less frequently but

we stay connected to this. Plan going forward is to reinvigorate the Infection Control Committee with a view for it to pick up on any Covid issues which currently sit with the Operating Model Monitoring (OMMG) and Scientific and Technical Advisory (STAG) groups.

In total fourteen patients have tested positive for COVID-19, with the last being in February 2021.

Patient Flow
There have been 9 patient admissions and 9 discharges during the period of 1 April 2021 – 31 July 2021.

Interim Clinical and Support Services Operational Policy
The policy is now on version 22 with the latest version implemented on 15 June 2021 with the re-introduction of mixing of patients across the site, the reintroduction of rehabilitation and compassionate outings, and in effect, described business as usual.

A monitoring process and group are very well established, and the group is chaired by the Director of Nursing, AHP and Operations. Daily figures are recorded and considered fortnightly at the OMMG. Going forward this will be reported to the Corporate Management Team (CMT).

Personal Protective Equipment
Since the last report there have been no or anticipated shortages of essential equipment for the immediate delivery of care.

Visiting
Personal and professional visiting are re-established, with imbedded operating procedures in place to minimise the risk of viral transmission.

STAG
Meetings continue fortnightly with a number of suggestions and implementations made.

Staff and Patient Vaccination
555 staff (88%) have received both vaccinations with 98 (86%) of our current cohort of 114 patients having had their second dose.

Work is underway on the delivery of Covid booster vaccinations. All patients will be offered the booster vaccine.

Lateral Flow Device Testing
Testing should be carried out twice per week and reported on the national portal. Results are currently 11%, which is down from 25% and this is in line with what is happening nationally. Lindsay Thomson has written to the co-Chairs of the Partnership Forum to see if they can think of any methods to encourage staff to take part in this; as it is voluntary we cannot enforce it.

State Hospital staff have experienced problems with the LFD reporting portal and this has been fed back to the Scottish Government LFD team.

The Committee were asked to note the report and to consider future content of the report.

Brian Moore welcomed the review of the structure and content of the report and suggested consideration be given to where information or data regarding activity levels sits as there are some key areas where we need updates.

Mark Richards suggested the Committee receive minutes from the Infection Control Committee on a quarterly basis.

Gary Jenkins suggested that bringing the 3 strands together into an exception report would be more useful to give broader coverage.

Lindsay Thomson advised the Committee that she will reduce the content in future reports and will include an appendix listing actions taken and will work with Mark Richards on whether the next Covid-19 report merges with the infection control report.

Cathy Fallon stated that it was useful to note all the work done by everyone in the Hospital, the success rate and positive shifts going forward.

The Committee noted the report.

11 LEARNING FROM FEEDBACK

The Committee **received** and **noted** the Learning from Feedback report presented by Mark Richards, Director of Nursing, AHPs and Operations. This report provides an overview of activity relating to feedback for the first quarter of the financial year 2021/22 (1 April to 30 June 2021).

Mark Richards advised that the PCIT regularly engage with the Patient Advocacy Service and Complaints Officer to ensure we deliver the best response we can and minimise duplication.

A wide range of methods continue to be utilised to share feedback, with 75 pieces of feedback processed this quarter, during a period in which the PCIT have been facilitating visiting in addition to this core area of service delivery. Feedback shared highlights:

- The 'effective relationships' indicator continues to feature primarily in relation to the nature of feedback shared.
- Meal service feedback is consistent with previous quarters, including 12 compliments and clear interest in theme meal menus.
- Recommencing the monthly takeaway meal facility has been well received.
- Frustrations relating to cancellation of Skye Centre placements, escalated to the complaints process.
- Value of facilitating a dedicated PPG session for patients with an Intellectual Disability.
- Acknowledgement of a more flexible visiting experience.
- Value of visiting within a dedicated environment.
- Continued delay with implementation of the patient shopping browsing experience.
- Challenges relating to provision of visitor travel services as a result of post-Covid operational issues with the external providers.

There was a suggestion from a patient around installation of a freezer within the Skye Centre and this is being taken forward

Compliments include visiting and peoples experience of using the family centre for visiting, with positive feedback from carers who value the facility; voice bubbles have been used to show comments from carers on their experience.

PPG continued to run during Covid-19; this is an important part of the PCIT business within the hospital and is now fully back up and running. Some learning in relation to engagement with intellectual disability group is highlighted in the report and a support group has been set up; it is intended that this will continue going forward.

It is hoped that there will be improvements in Skye Centre placements in the future due to successful recruitment of staff.

Stuart Currie stated that the compliments are very impressive. Mark Richards advised that Sandie Dickson is tireless in her efforts around how we can engage with patients in the Hospital and the

patient voice also comes through the Operating Model Modelling Group.

Cathy Fallon asked that the Committee's thanks are passed to Sandie Dickson and her team.

The Committee noted the report.

12 LEARNING FROM COMPLAINTS

Members **received** and **noted** the Learning from Complaints Report presented by Margaret Smith, Board Secretary. The report provides the Committee with an overview of activity of complaints, concerns and enquiries for Q1 of the financial year 2021/22.

13 new complaints were received and eight complaints were closed.

Of complaints received, the main issue raised was that of clinical treatment and this included grounds access, the cancellation of placements and diagnosis/medication.

In relation to complaints closed in this quarter, the report indicates the main issues raised, as well as whether the complaint was considered to have been upheld, partially upheld or not upheld. In this quarter, TSH was successful in resolving all of the complaints, which were closed, at Stage 1 of the MCHP.

There was an increase in the number of complaints relating to access to patient activity, particularly in the Skye Centre. This underlines the way in which learning from complaints is a useful tool for the organisation to actively listen and respond to patient and carer views.

Mark Richards advised that there were challenges in delivering activity at the level we would wish to see due to vacancies within the Skye Centre, but good progress has been made to fill these gaps and this month we will have 5 new staff staring within the Skye Centre which will make a significant difference; there are still 4 vacancies to be filled.

The Committee noted the report.

13 INCIDENT REPORTING AND PATIENT RESTRICTIONS

The Committee **received** and **noted** the Incident Reporting and Patient Restrictions Paper, presented by Lindsay Thomson, Medical Director and Allan Hardie, Head of Risk Management.

- PAA activations have decreased from the previous quarter. During June there was 6 activations. This included 3 activations for 1 patient when he was newly admitted. 1 activation was on the grounds when a patient from Iona was on an escorted walk.
- Patients are given the choice to provide a sample either urinalysis or oral fluid test. The majority of the patients opt to use the oral fluid test. During this quarter there was 3 positive OFT tests. In April in Arran ?? tested positive for codeine. In May 2 patients tested positive for cocaine (Arran and Iona.) The lab is refuting the possibility of any error; the RMO and Clinical Team are sure that this must be a false positive as one patient is on level 3 observations so staff are with him at all times; the other patient has no history of drug misuse. Drugs dogs have been brought in and there were no positive findings.

Allan Hardie advised that there were 256 incidents reporting in Datix, this is an increase from 249 in the last quarter. 13 incidents were rejected. Of the remaining 243 incidents requiring review, all except one have been finally approved.

- *'Behaviour'* had the highest number of incidents in the H&S category at 36; this is a decrease of 24 from the 60 incidents reported in the previous quarter. 25 incidents were recorded as

"Threatening/Intimidating Behaviour" 9 as "Other" and 2 as "Destructive. 10 of these incidents took place in Arran 1 from 1 patient, and 2 incidents in Arran 2. 15 incidents came from a mix of patients and wards in Iona Hub, 2 in Mull, 5 in Lewis and 2 in Skye Centre.

- *'Slip/Trip/Fall – Staff'* decreased from 7 to 2 in Q1.
- *'Assault'* decreased from 4 to 2 however staff members were injured in both incidents resulting in 2 RIDDOR notifications to HSE.
- *'Slip/Trip/Fall – Patient'* increased from 3 to 11 in Q1. 5 took place during time on hospital grounds, 4 in bedrooms and 2 within the ward day area.
- *'Sexual'* Incidents increased from 4 to 8 in Q1. 1 Patient accounted for 5 incidents and another for 2. All were reported as 'Inappropriate Sexual Behaviour'. A group of 3 patients were also observed by staff members to be discussing sexual activity.
- *'Verbal Aggression/Abuse'* remained the same with 10 incidents in Q1. 7 were 'patient to staff' 1 'patient to patient', 1 'carer to patient' and 1 'Other' which was not aimed at any individual.
- 'Attempted Assault' remained the same at 14. 11 incidents were recorded as 'patient to staff' and 3 'patient to patient' Incidents came from a varied number of wards and patients.
- 3 RIDDORS in total in Q1, 2 from previously mentioned assault incidents and 1 from 'Moving and Handling' in which a housekeeper tried to lift overfilled bins and hurt their back.
- 1 incident of "Injured by Animal" This was during an attack from seagull, another similar incident took place in July.
- 66 Staff resource incidents were recorded during this period, showing an increase of 47 on the previous quarter. In the last quarter staff incidents have increased from 9 in April, 14 in May to 43 in June.
- '*Breaches*' remained similar at 12 incidents in this quarter. The incidents reported included loss of item x 4, telephone incidents x 2, vape taken into hospital, drone sighting, pornography found in patient room, escorting patients without radio and a metal shard found in a DVD security tag.
- '*Other'* incidents remained similar at 4: the incidents related to missing stamps, missing grounds access card, individual attempting to film at TSH perimeter and being unable to contact an on-call RMO.
- '*Prohibited or Restricted Items*' remained similar in Q1 at 6, involving items found within rooms/wards, 2 incidents of items being secreted in rectum on admission, metal found within hospital perimeter and discovery of a nicotine inhalator during searching.
- 'Substances' increased from 1 to 3. 2 incidents involved discovery of substances after bowel movements of a recently admitted patient. Another incident involved a patient being seen to snort an unknown substance.
- *'Clinical Waste*' incidents related to staff not adhering to Linen Segregation, Bagging and Tagging National Infection Prevention & Control Manual. Incidents have decreased from 12 to 8 in this quarter. 2 incidents occurred in Mull, 3 in Iona and 3 in Arran.
- *'Patient suspected contagious illness'* decreased from 4 to 2, incidents involved patients experiencing vomiting and loose stools.
- '*Self-Harming Behaviour*' decreased from 25 to 14: 3 different patients were reported as having self-harmed in this quarter down from 6 in Q4. 8 occurred in Mull 1 from 1 patient, 5 from 1 patient in Iona 2 and 1 from 1 patient in Iona 3.
- 'Medicine Administration' Incidents remained similar in Q1 at 4. 2 incidents involved secreted medication, patient being given wrong medication and patient being given incorrect dose.
- 'Medication Other' incident is still under review.
- '*Equipment Malfunctions'* remained similar at 6 incidents. The incidents involved lock failure (2), hub door access, anti-barricade failure, issues with patient telephone numbers/system (2).
- '*Service'* Incidents increased from 0 to 2, involved loss of IT service.
- *'Other'* and *'Damage'* Incidents involved wear and tear of fixtures and fittings.
- The '*Breach of Staff Confidentiality*' incidents decreased to 1, involved staff leaving computer session logged in.
- *'Breach of Patient Confidentiality'* remained at 3 in Q1. Incidents involved patient details being sent wrong email address (2) and potential breach of policy from staff member.
- *'Other'* Involved an error resulting in patients being unable to register to vote in election in May and email being send to the wrong health board.

Cathy Fallon asked if clinical waste was an issue that should be highlighted as an area of concern going forward. Allan Hardie advised that the Head of Estates and Facilities has reviewed this, and it is thought to be due to staff education. Mark Richards advised that bagging and tagging of linen is a challenge for us but levels now are low. When it has been identified where the bags have come from, Senior Charge Nurses are informed and asked to label them properly.

Gary Jenkins informed the Committee on the sexual assault issue; this was a group of 3 patients discussing sexual activity and was about a potential attack on staff by patients.

The report was noted by the Committee.

14 CLINICAL MODEL

Members **received** and **noted** the update on restarting the Clinical Model project presented by Lindsay Thomson, Medical Director.

Lindsay Thomson advised the Committee that work had been progressing well on the Clinical Model until Covid struck us and we are now picking this up again and restarting the process. A mapping exercise has been undertaken and will be presented to the Board on 26 August.

Cathy Fallon stated that any questions on the full report will be taken at the Board meeting.

15 CAT 1 20/01

Members **received** and **noted** the redacted CAT 1 20/01 report relating to an incident on 15 May 2020 when a patient created a makeshift weapon and made threats towards staff which required assistance from Police Scotland.

Allan Hardie gave the Committee a brief overview of the incident and the review that took place.

The Committee were advised of the deployment of the Police Firearms Unit as opposed to the Public Order Unit and discussed the issues around this.

Gary Jenkins advised that he has written to the Police Incident Review Committee to ask if they could review the response provided; they have the same intelligence on the patient that we do, and their view was that this was the appropriate response.

Allan Hardie advised that we now have a local Police Liaison Officer, and we are currently putting together a Memorandum of Procedures which will give the Police further information to assist in their decision making when we have an incident. We are also continuing with familiarisation visits to the Hospital

16 CAT 1 20/02

Members **received** and **noted** the redacted CAT 1 20/02 report relating to an incident on 19 July 2020 when banging noises were heard from a patient bedroom and the patient was found to be striking the door with a bottle, which resulted in the observation panel and frame coming out.

Allan Hardie provided the Committee with an overview of the incident and investigation.

The Committee were happy with the recommendations contained within the report.

Cathy Fallon asked if the negotiator had a contract or were employed by the Hospital. Lindsay

Thomson advised that they were a member of staff who had retired in mid-June and was coming back on a retire and return basis but their contract had not yet been issued by the HR Department and they were covered for working with us.

David McConnell asked if there was an ongoing risk with the red plastic chairs. Gary Jenkins advised that all the chairs have now been replaced and are suitable for use in a high secure hospital.

17 CAT 1 20/03

Members **received** and **noted** the redacted CAT 1 20/03 report relating to a patient death by choking.

Allan Hardie provided the Committee with an overview of the incident and advised that the recommendation on improving the telephone system has now been rectified.

Cathy Fallon asked about support for staff following the incident. Lindsay Thomson advised that support is available during hot and cold debriefs and there is also the Staff Wellbeing Centre in Harris or through occupational health if required.

Brian Moore advised that this is the first time he had seen papers on Cat 1 incidents and he found them to be useful and interesting and, as a Board, they might need to reflect on how best the non-Executive Directors learn from these reports and how they oversee or review the findings and they need to have an understanding of how the recommendations are being progressed and if there are any issues with regard to taking them forward.

Margaret Smith to include this on the agenda for the next Board development day.

Action: Margaret Smith

18 DISCUSSION ITEM

There was no item for discussion at this meeting due to Covid-19 update paper. It was agreed that this will resume from February 2022.

19 AREAS OF GOOD PRACTICE / AREAS OF CONCERN

The Committee noted two areas of good practice:

OMMG Annual Report
Infection Control Annual Report

The Committee also noted one area of concern around clinical waste.

20 WORKPLAN

The Committee **noted** the Clinical Governance Committee Workplan. The Annual Duty of Candour Report was due to be presented to this meeting, but a postponement was requested due to timing of national reporting. It will come to the next meeting. This should be moved to the next quarter in the workplan.

21 ANY OTHER BUSINESS

There was no other business raised at this time.

22 DAY, DATE, TIME AND VENUE FOR NEXT MEETING

The next meeting will be held on Thursday 11 November 2021 at 9.45am via MS Teams

The meeting concluded at 12.40pm.

THE STATE HOSPITALS BOARD FOR SCOTLAND

CLINICAL FORUM

Minutes of the Clinical Forum held at 10.00am on Tuesday 28 September 2021 via Microsoft Teams CF(M) 21/05

Present:

Dr Sheila Howitt	*Consultant Forensic Psychiatrist **(Chair)***
Dr Kerry Jo Smith	*Clinical Psychologist*
Carolin Walker	*Professional Nurse Advisor*

Apologies:

Alan Blackwood	*Lead Nurse*
Dr Aileen Burnett	*Consultant Clinical Psychologist*
Dr Jana De Villiers	*Consultant Psychiatrist*
Julie Warren	*Corporate Services*

In Attendance:

Sandie Dickson	*Person Centred Improvement Lead*
Jennifer Gardiner	*Senior Charge Nurse*
Jim Irvine	*Head of Security*
David McCafferty	*PA to Chair/CEO, Corporate Services **(minute)***
Brian Moore	*Chairman (Item 8 & 9)*
Sheila Smith	*Clinical Effectiveness Team Leader*
Monica Merson	*Head of Planning & Business (Items 14 & 15)*
Fiona Warrington	*Clinical Pharmacist*

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

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

NOTED.

2 CONFLICT(S) OF INTEREST

There were no conflicts of interest declared.

NOTED.

3 APPROVAL OF PREVIOUS MINUTES

The minutes of the previous meeting held on 27 July 2021 **were approved** as an accurate record. The group agreed that it would be appropriate to have a Liaison Security Manager in regular attendance rather than the Security Manager.

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 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 would convene this afternoon and an update would be provided at the next Clinical Forum.

NOTED.

(b) Medical Advisory Committee

Members **received** and **noted** the approved Minutes of the Medical Advisory Committee held on 14 June 2021. The July meeting did not go ahead. At the September meet, it was noted that MAC discussed grounds access restrictions and a letter had been submitted to the Corporate Management Team. A meeting had then been arranged with Gary Jenkins, Khuram Khan and Sheila Howitt to discuss this in greater detail. The Operational Model Monitoring Group will continue to monitor the impact of grounds access restrictions.

NOTED.

(c) Psychology Professional Practice Meeting

Kerry Jo Smith provided a verbal update **to note**, including notification that therapy groups such as Making Healthy Changes and Life Minus Violence had returned to meeting inperson. Mentalised based therapy conducted electronically had concluded and full face to face MBT was expected to begin around the end of October. Low Intensity Work Group would begin in October to include new patient admissions. New psychology staff had taken up post to include two advanced nurse practitioners. A number of psychologists had been involved with ADOS training to assist with the diagnosis of Autism Spectrum Disorders and developmental difficulties in admission patients. Increased numbers of patients were now returning back to groups on the wards.

NOTED.

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

Members **received and noted** the written update from Marcus Topping, Practice Nurse dated 16 September 2021. Of note, regular GP service meetings were reinstated last week with TSH staff and it was important to note the service being provided was thought to be above that of the standard currently being offered in the wider community.

NOTED.

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

It was agreed that an update would be provided at the next meeting in November and minutes would be shared when available.

NOTED.

8 CHAIR UPDATE

Brian Moore, Chairman provided members with an update **to note**, which included the Board Meeting on 26th August. In relation to the Barron report, a government response was awaited. Discussion around this as well as women's services continues at Chairs and Chief Executive meetings. Alongside this, there were ongoing consultations into Adult Social Care review.

eHealth and homeworking and the consideration taken for each staff group was discussed. An update on whistleblowing was noted as well as an update on the Corporate Governance action plan. A lengthy discussion around whistleblowing culture within the State Hospital took place. Whistleblowing training was noted to be positive at around 79% completion rate. The Board supported another round of engagement sessions around the Clinical Model and how patient numbers are impacting this. Non-executives had met to debate on effectiveness of committees. A presentation was given on how the Board could become more transparent with an opportunity to live stream future Board meetings, with benefits and disadvantages discussed. This will be revisited in spring time.

NOTED.

9 UPDATE FROM CHAIR OF CLINICAL GOVERNANCE COMMITTEE

Brian Moore advised the group that he attended the last meeting. **To note**, Adverse Events and Cat1 events were discussed and issues were found to be of interest from a Board perspective and provided the opportunity for learning. The Board Development Day was noted and discussions included safe staffing and staffing issues across the health system. There was agreement that the Chair of the Clinical Governance Committee should be invited to the Clinical Forum.

NOTED.

ACTION: David McCafferty (complete)

10 TRIANGLE OF CARE UPDATE

Members were provided with an update on Triangle of Care **to note**. Baseline assessment had begun and next step was to complete ratified assessment with support from external Forensic Network colleagues. Good progress was noted to be made with 32 of a possible 39 indicators green status. Delays were reported due to Covid-19. Few outstanding indicators were noted as any cause for concern. Formal self-assessment would be completed and results would come back to Clinical Forum as an update.

NOTED.

11 REFLECTION ON ANNUAL REVIEW 2021

Chair of the group **noted** that the Annual Review had not yet taken place with dates currently being sought. As yet there has not been clarity on how the Clinical Forum will provide input into this.

NOTED.

12 REVIEW OF AUDIT OF GROUNDS ACCESS POLICY

The group were provided with a verbal update **to note** on progression of grounds access policy audit review. This was confirmed to be rolled out as an electronic format, but due to issues around staffing and Covid-19, had been met with delays. Live testing confirmed as ready to be implemented with a pilot originally planned for Lewis Hub, however this would now be site-wide when staffing permits. EHealth and the Security Information Analyst were noted to be involved in the delivery of this, and training was expected to follow initial implementation.

NOTED

13 FEEDBACK FROM DIGITAL INCLUSION GROUP ON MBT SESSIONS

An update paper was provided to group **to note**, written by the Skye Centre Manager, which sets out feedback from the Digital Inclusion Group on MBT sessions. The video conferencing facility has encountered issues and feedback highlighted this to be a challenging experience for both group facilitators and patients. The 'Near Me' video platform was being reviewed to extend the functionality of the system as this is thought to be an option which is reliable, easily accessible and provides clear quality images and sound. This was hoped to commence in October 2021.

NOTED

14 DISCUSSION ON REMOBILISATION PLAN VERSION 4

Presentation was provided by Head of Planning & Business **to note,** and gave insight into the Remobilisation Plan Version 4. This version would include winter planning and updates for October – March 22 to include physical healthcare needs, promotion of staff wellbeing, implement changes to the Clinical Model and improve digital capability and resilience. Next steps in the process was submission of the plan to the Scottish Government by 30th September and await Scottish Government review feedback thereafter.

NOTED.

15 UPDATE ON CLINICAL MODEL

Two documents were provided to the group **to note** which gave details into the progression and ongoing development plans for the Clinical Model. Details around the key issues such as patient mapping were covered within the paper as well as analysis of mapping, patient flow and MSR usage, discharges and patient transfers list. It was agreed that patient flow from high to medium secure would have to be addressed as this would be the key to reducing patient numbers. Next steps would be influenced by emerging views from staff groups which would feed into the consideration of options to progress the Clinical Model along with views from carers, various stakeholders and patients. There would be collaboration and alignment of activity, and it was noted that guidance for different types of wards should reflect what was to be achieved. Desktop activity would be revisited to help understand how many wards are actually required and financial aspects would be explored. Key points from this discussion included the need to engage regularly, front line staff should be reached to allow for the voicing of any concerns, the need for a range of criteria and plans to be put in place before any further steps were taken, and the need to have creativity at the forefront of plans as well as the realisation to recognise if things were not working as well as initially anticipated. Item will remain on the agenda for any updates.

NOTED.

16 UPDATE FROM DIGITAL INCLUSION GROUP

An update from Digital Inclusion Group paper was presented to the group to note. Paper sets out a number of projects which are ongoing. Of particular note, the patient internet browsing experience pilot was reported to be up and running with positive feedback received generally from patients.

NOTED.

17 REVIEW OF EQUALITY OUTCOMES WORKSHOP REPORT

An Equality Outcomes report and priority criteria document were presented to the group **to note.** A more fragmented approach had been developed with a requirement to mitigate risk of Covid-19 with restrictions on in-person events and limited patient use of virtual platforms. Stakeholder forums took place with 13 inequalities highlighted for consideration of inclusion within TSH Equality Outcomes,

of which 7 were priorities. Meetings would be arranged with leads to work up an action plan and six monthly updates would be provided on progress. Outcomes would be reported back to this group if any issues are met on the delivery of these.

NOTED.

18 AOCB

There was a sense-check around the group to highlight papers tabled for discussion at the Clinical Forum which had been discussed at other meetings. It was agreed that a Clinical Forum Teams Channel would be set up to allow for papers to uploaded which may not require full discussion at the forum, and also to help improve communication between meets.

NOTED.

ACTION: David McCafferty

19 DATE AND TIME OF NEXT MEETING

The next meeting of the Clinical Forum would take place at 10am on Tuesday 23 November 2021 via Microsoft Teams.

Meeting concluded at 1247 hours

Paper No. 21/96

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	23 December 2021
Agenda Reference:	Item No: 14
Sponsoring Director:	Director of Nursing, AHPs and Operations
Author(s):	Director of Nursing, AHPs and Operations
Title of Report:	Achieving Safe Staffing
Purpose of Report:	For Noting

1 SITUATION

Achieving safe staffing is currently rated high as a corporate risk, as staffing deficits risk impacting negatively on patient experience and outcomes.

This paper updates the Board on current challenges, underlying factors, and aims to offer assurance on the actions taken to date to mitigate against the risk, and actions that are in the pipeline as further mitigation.

2 BACKGROUND

The key issues to be considered are as follows:

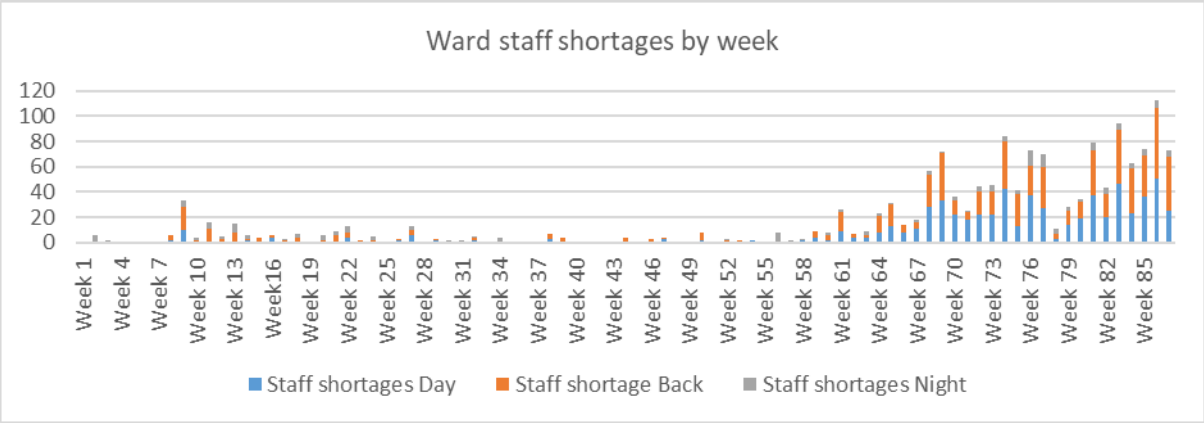
- Safe staffing is rated as a high risk on the Corporate Risk Register.
- There are daily challenges in achieving safe staffing in nursing. There have been weeks when there has been close to 200 deficits that have needed filled across our wards, and not all shifts have been filled.
- There are multiple factors that are affecting staff availability day to day, but levels of sickness absence, vacancies and limited supplementary staffing options are the most significant.
- For planning and performance purposes, sickness absence is assumed at 5%. It is currently at 15%.
- There are 13 vacancies at present from a funded establishment of 295 WTEs.
- There are 20 projected retirements between now and 31st March 2022, which will further impact on the availability of staff. 14 of these are registered nursing staff.
- A recruitment plan is in place to ensure that the current vacancy gap is bridged, and to mitigate against the risk of the cluster of retirements in the final quarter of this financial year.
- Work is underway to process the recruitment of 7 student nurses on a fixed term contract basis in line with the national drive to recruit students within Boards.

- Work has been undertaken in partnership to agree a way forward with developing a nurse bank. This was agreed at the CMT on 15 December, and will provide an additional supplementary staffing option.
- A 'safe to start' framework was approved by CMT on 15 December, and sets out a multi-professional, risk informed decision making framework to achieve safe staffing.
- Ensuring delivery of safe care that meets the care and treatment needs of our patients is of fundamental importance, and is at the heart of the approach described.
- The approach described is consistent with national workload developments aligned to safe staffing legislation and the need to focus on real time staffing.

3 ASSESSMENT

There has been a significant change in reported staff shortages over the past 12 months. Monitoring data from the Operating Model Monitoring Group shows that 12 months ago, shift fill deficits were infrequent, whereas this in now a regular occurrence. It is important to note that for part of this reporting period, there was a limited clinical service delivery model, with full remobilisation only realised at the end of June 2021. This will have had an impact on staff requirements and may have masked the issue of staffing capacity and service resilience.

Remobilisation was at week 64 on the table below.



There are multiple factors that are affecting staff availability day to day, but levels of sickness absence, vacancies and limited supplementary staffing options are the most significant.

For planning and performance purposes, sickness absence is assumed at 5%. It is currently at 15% in nursing.

There are 13 vacancies at present from a funded establishment of 295 WTEs.

There are 20 projected retirements between now and 31st March 2022, which will further impact on the availability of staff. 14 of these are registered nursing staff.

Recruitment activity is progessing well, despite the challenging recruitment climate nationally. 5 new staff nurses started on 5 December, and there are 13 candidates being interviewed for staff nurse posts on 21 December.

A recent advert for nursing assistants was met with a strong response, and 48 applications have been received. Interviews are scheduled for 20, 22 and 23 December, and 24 candidates are being interviewed.

Recruitment of students has been progressed in line with the recent Directorate Letter, with 7 student nurses being successful in their applications. These students will join the workforce on a less than full time contract basis with staff working between 7.5 and 15 hours.

A 'Safe to Start' framework and guidance has also been developed, and this was agreed by the CMT of 15 December. This aims to provide a risk based framework and guidance to support consistent, timely and patient centred decision making regarding deployment of staff, and aims to help achieve safe staffing with the purpose of ensuring the delivery of planned care and treatment in line with assessed needs.

The framework describes a risk graded model (green to black), with staffing deficit parameters associated with each level. Against each risk level, there is guidance on actions which may be taken to mitigate against the presenting risk.

As our teams are multidisciplinary, decisions regarding varying the deployment of staff must ensure that the consequences are considered across the service. For example, continuity of treatment on a sessional basis should, as far as possible, not be adversely impacted by decisions related to temporary redeployment of staff.

Finally, a short life working group was commissioned by the CEO to consider the issue of supplementary staffing and bank. The group has now scoped a way forward to develop a nurse bank for The State Hospital as a means of realising additional supplementary staffing capacity. This was discussed at the CMT on 15 December 2021, and an implementation group has now been commissioned. This group will start to meet in January, with the aim of having a having a model ready for implementation by the start of the next financial year.

4 RECOMMENDATION

The Board is asked to **note** this update.

Paper No. 21/96

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	To support safe service delivery
Workforce Implications	These are fully explained within the report, focused on nursing.
Financial Implications	Not specified as remit of reporting but considered as part of directorate workforce planning.
Route To Board Which groups were involved in contributing to the paper and recommendations.	Corporate Management Team
Risk Assessment (Outline any significant risks and associated mitigation)	Risk analysis outline within reporting
Assessment of Impact on Stakeholder Experience	Considered as part of workforce planning.
Equality Impact Assessment	Not required
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	Not relevant
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One X There are no privacy implications. □ There are privacy implications, but full DPIA not needed □ There are privacy implications , full DPIA included.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	23 December 2021
Agenda Reference:	Item No: 15
Sponsoring Director:	Director of Workforce
Author(s):	HR Advisor
Title of Report:	Attendance Performance Report
Purpose of Report:	For Noting

1 SITUATION

This report provides information on sickness absence within the State Hospital for the period up to 31 October 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

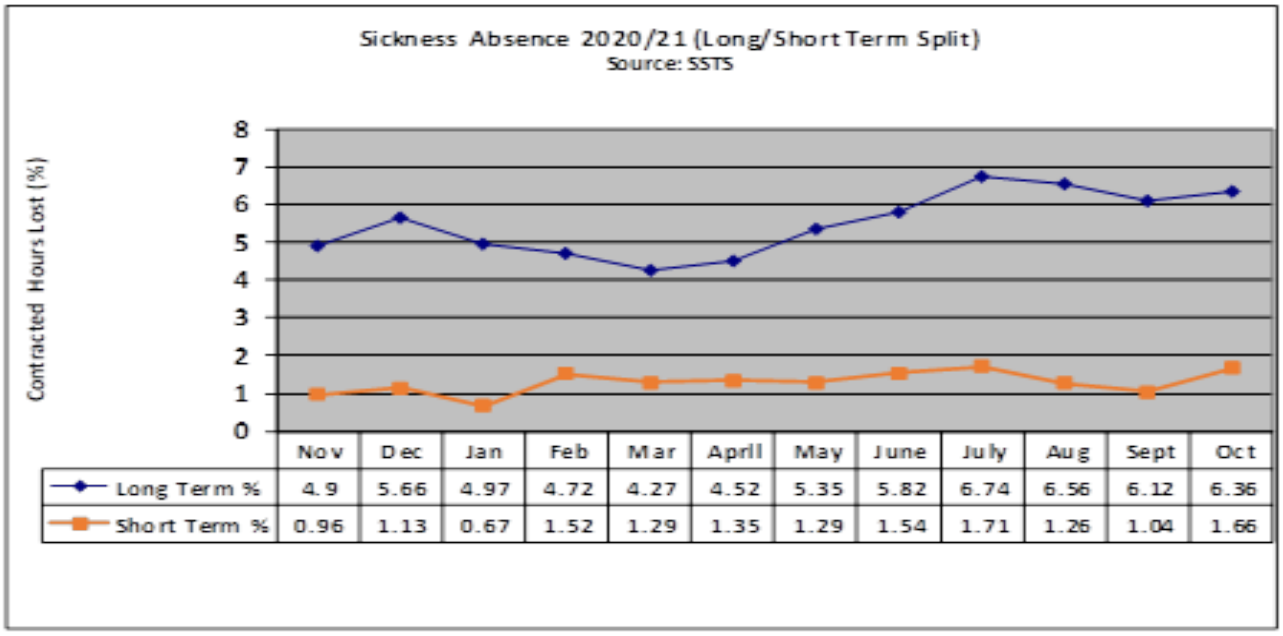
The sickness absence figure from 1 October 2021 to 31 October 2021 is 8.02% with the long/short term split being 6.36% and 1.66% respectively. The total hours lost for this period is 7,937 which equates to 48.76 WTE.

The monthly absence figure has increased by 0.86% from the September 2021 figure of 7.16%. The September 2021 long/short term split was 6.12% and 1.04% respectively.

The current average rolling 12-month sickness figure is 5.88% for the period 1 November 2020 to 31 October 2021. The long/short term split is 4.61% and 1.26% retrospectively.

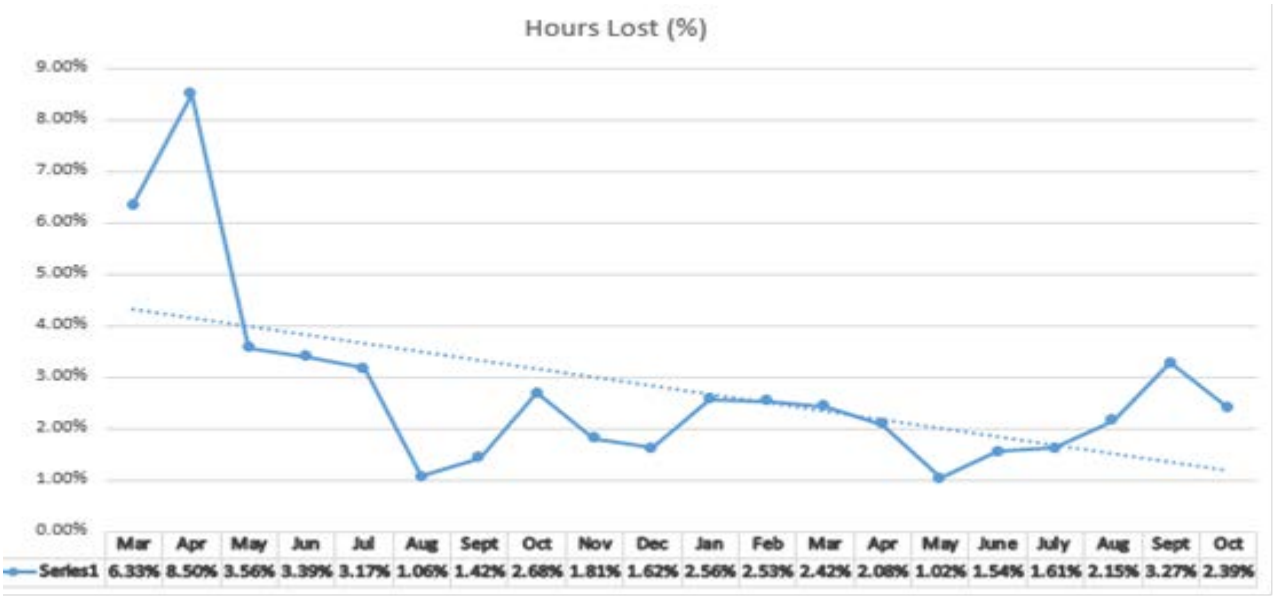
This data is broken down further into monthly detail in the following tables:

Table 1 - 2021/22 Sickness Absence (SSTS)



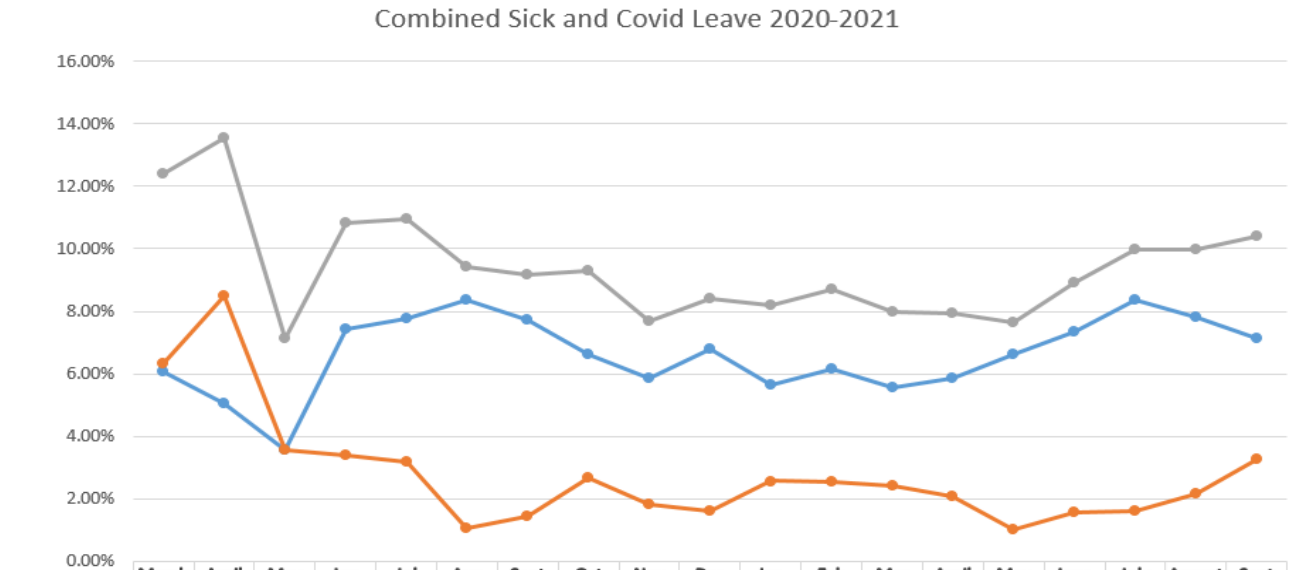
	Nov	Dec	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct
Long Term %	4.9	5.66	4.97	4.72	4.27	4.52	5.35	5.82	6.74	6.56	6.12	6.36
Short Term %	0.96	1.13	0.67	1.52	1.29	1.35	1.29	1.54	1.71	1.26	1.04	1.66

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



	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct
Series1	6.33%	8.50%	3.56%	3.39%	3.17%	1.06%	1.42%	2.68%	1.81%	1.62%	2.56%	2.53%	2.42%	2.08%	1.02%	1.54%	1.61%	2.15%	3.27%	2.39%

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



	March	April	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June	July	August	Sept
Sickness	6.07%	5.05%	3.56%	7.44%	7.78%	8.36%	7.73%	6.60%	5.86%	6.79%	5.64%	6.16%	5.56%	5.87%	6.64%	7.36%	8.35%	7.82%	7.14%
Covid	6.33%	8.50%	3.56%	3.39%	3.17%	1.06%	1.42%	2.68%	1.81%	1.62%	2.56%	2.53%	2.42%	2.08%	1.02%	1.54%	1.61%	2.15%	3.27%
Total	12.40%	13.55%	7.12%	10.83%	10.95%	9.42%	9.15%	9.28%	7.67%	8.41%	8.20%	8.69%	7.98%	7.95%	7.66%	8.90%	9.96%	9.97%	10.41%

Table 4 - National Comparison Data (SWISS)

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

	Absence Rate			Instances			Absence Reason	
	Total	Long Term [1]	Short Term [2]	Total	Long Term [1]	Short Term [2]	Yes	No [3]
Scotland	**5.26**	**3.64**	**1.62**	**226,927**	**36,098**	**190,829**	**187,628**	**39,299**
NHS Ayrshire & Arran	4.87	3.50	1.37	11,637	2,139	9,498	10,310	1,327
NHS Borders	5.01	3.37	1.64	4,229	623	3,606	3,184	1,045
NHS National Services Scotland [4]	3.77	2.60	1.18	3,516	477	3,039	3,073	443
NHS 24	7.91	5.27	2.64	4,339	618	3,721	3,892	447
NHS Education For Scotland	1.52	1.08	0.44	832	112	720	404	428
Healthcare Improvement Scotland	2.70	1.78	0.93	384	41	343	343	41
NHS Health Scotland [4, 5]	-	-	-	-	-	-	-	-
Public Health Scotland [4, 6]	2.49	1.55	0.94	1,070	104	966	830	240
Scottish Ambulance Service	7.12	5.23	1.90	8,169	1,629	6,540	7,337	832
The State Hospital	5.88	4.61	1.26	636	188	448	581	55
National Waiting Times Centre	5.11	3.33	1.77	2,718	453	2,265	2,221	497
NHS Fife	5.30	3.75	1.55	10,998	1,998	9,000	9,463	1,535
NHS Greater Glasgow & Clyde	5.85	4.23	1.62	53,874	10,286	43,588	47,219	6,655
NHS Highland	4.89	3.33	1.56	13,152	1,721	11,431	8,211	4,941
NHS Lanarkshire	6.12	4.55	1.58	15,672	3,373	12,299	12,747	2,925
NHS Grampian	4.14	2.46	1.68	23,572	2,372	21,200	17,368	6,204
NHS Orkney	4.56	3.09	1.47	813	107	706	697	116
NHS Lothian	4.80	3.01	1.79	37,549	4,540	33,009	31,005	6,544
NHS Tayside	5.28	3.58	1.70	17,744	2,670	15,074	14,264	3,480
NHS Forth Valley	6.01	4.38	1.62	7,887	1,493	6,394	7,163	724
NHS Western Isles	5.40	3.76	1.64	1,350	197	1,153	1,063	287
NHS Dumfries & Galloway	5.25	3.57	1.68	5,756	867	4,889	5,320	436
NHS Shetland	3.48	2.10	1.38	1,030	90	940	933	97

4 RECOMMENDATION

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

MONITORING FORM

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

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	23 December 2021
Agenda Reference:	Item No: 16
Sponsoring Director:	Director of Workforce
Author(s):	Director of Workforce
Title of Report:	Whistleblowing Update
Purpose of Report:	For Noting

1 SITUATION

The role of the Independent National Whistleblowing Officer (INWO) was implemented from 1st April 2021. This is linked to the Scottish Public Services Ombudsman (SPSO).

2 BACKGROUND

As explained previously, this role provides a mechanism for external review of how a Health Board, primary care or independent provider has handled a whistleblowing case. The rescheduled launch date of 1 April 2021 was in recognition of the risk of pressures on Health Boards over the winter period. The Whistleblowing Standards that SPSO have developed as a model procedure for handling whistleblowing concerns raised by staff and others delivering NHS services, was formally published on 1 April 2021. For NHS Scotland staff, these form the 'Once for Scotland' Whistleblowing Policy.

3 ASSESSMENT

The State Hospital fully launched the Whistleblowing Standards and the national policy. This included testing of the Datix template and the launch of Learn-Pro modules as the foundation for staff training complimented by a targeted communications exercise. A key requirement of the revised standards is notification of case incidence to the board and staff governance committee. This is the third report of this nature and confirms that two cases have been raised during the period 1 April 2021 to date.

The first case investigation has been concluded and feedback has now been given to the individual. However, they remain concerned about the investigation process and therefore the next stage will be for them to make contact with the INWO and ask them to investigate. This will be the final stage of the process.

The second case is currently subject to investigation at Stage 2 within the standards.

4 RECOMMENDATION

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

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Links to the National Guidance for Whistleblowing set by the Scottish Government
Workforce Implications	Positive measure in support of Staff Governance Standards.
Financial Implications	N/A
Route to Board Which groups were involved in contributing to the paper and recommendations.	Via HR and Wellbeing Group / Board requested on workplan
Risk Assessment (Outline any significant risks and associated mitigation)	N/A
Assessment of Impact on Stakeholder Experience	Failure to adopt would undermine the principles of Partnership Model and Employee Engagement.
Equality Impact Assessment	N/A
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	N/A
Data Protection Impact Assessment (DPIA) See IG 16.	**X There are no privacy implications.** □ There are privacy implications, but full DPIA not needed □ There are privacy implications, full DPIA included.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	23 December 2021
Agenda Reference:	Item No: 16b
Author(s):	Board Secretary
Title of Report:	Whistleblowing Champion Update
Purpose of Report:	For Noting

1 SITUATION

The Board is asked to provide an update on the Whistleblowing Champion's role at Board Level.

2 BACKGROUND

On the 7 November 2021 Humza Yousaf, MSP, Cabinet Secretary for Health and Social Care, wrote to Health Boards' Whistleblowing Champions. He requested a short update on the Whistleblowing Champion's role at Board level, and detail of any work to ensure and promote a more positive and engaging culture within the Board.

A copy of the letter from the Cabinet Secretary is attached.

3 ASSESSMENT

The letter also refers to a request from the then Health Secretary in December 2020 for an update on preparations for the implementation of the Whistleblowing Standards. A copy of the response was shared with the State Hospital Board Members at the December 2020 meeting.

The response to the Cabinet Secretary for Health and Social Care advises that currently the State Hospital's Non Executive Director Whistleblowing Champion's position is vacant. A copy of the draft response is attached.

4 RECOMMENDATION

The Board are asked:

- To note the content of the letter from the Cabinet Secretary.
- To note the draft response.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	As part of National Guidance for Whistleblowing set by the Scottish Government
Workforce Implications	Positive measure in support of Staff Governance Standards.
Financial Implications	N/A
Route to Board Which groups were involved in contributing to the paper and recommendations.	Board awareness - requested by Scottish Government
Risk Assessment (Outline any significant risks and associated mitigation)	No risk identified
Assessment of Impact on Stakeholder Experience	Supporting staff model
Equality Impact Assessment	N/A
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	N/A
Data Protection Impact Assessment (DPIA) See IG 16.	**X There are no privacy implications.** □ There are privacy implications, but full DPIA not needed □ There are privacy implications, full DPIA included.

THE STATE HOSPITALS BOARD FOR SCOTLAND

APPROVED Minutes of the meeting of the Staff Governance Committee held on Thursday 19 August 2021 at 9.45am via MS Teams, The State Hospital, Carstairs.

SG(M)21/03

Present:

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

In attendance:

Director of Workforce	Linda Davidson
Training and Professional Development Manager	Sandra Dunlop (part)
Chief Executive	Gary Jenkins
Head of Corporate Planning & Business Support	Monica Merson
UNISON Staff-Side Representative	Michelle McKinlay
Board Secretary	Margaret Smith
Director of HR and Wellbeing	John White
PA to Director of HR and Wellbeing	Rhona Preston (minutes)

In attendance – part:

Principal Occupational Health Advisor / Contract Manager	Kay Japp
Consultant Occupational Health Physician	Dr Sergio Vargus-Prada
Occupational Health Advisor	Karen McGurk
Occupational Health Secretary	Caron Casey

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

Pam Radage welcomed everyone to the meeting, no apologies were received for noting. Linda Davidson, Director of Workforce was welcomed to the meeting. This meeting will be Tom Hair and John White's final Staff Governance Committee due to them both retiring. Salus Occupational Health staff in attendance were welcomed to the meeting.

2 CONFLICTS OF INTEREST

There were no conflicts of interest raised.

3 MINUTES OF THE PREVIOUS MEETING HELD ON 20 MAY 2021

The Committee approved the Minutes of the previous meeting held on 20 May 2021 as an accurate record.

4 ACTION POINTS AND MATTERS ARISING FROM THE PREVIOUS MEETING

Health, Safety and Welfare Committee
Updates from the Health and Safety meetings will be shared via the Partnership Forum.

5 SALUS OCCUPATIONAL HEALTH ANNUAL REPORT AND PRESENTATION

Members of the Committee received and noted the Salus OH Annual Report, April 2020 to March 2021 as presented by Kay Japp, Principal Occupational Health Advisor / Contract Manager.

The presentation highlighted the following key areas;

Service Provision; an overview of all services provided.

KPIs and Measurements; a summary was provided noting that KPIs were implemented in April 2019 and the report reflects the 2nd full year of this data recording.

Key Priorities for the State Hospital; Salus OH staff; members were advised of the Salus OH Staff and their roles in providing a competent, quality service to the Hospital.

Plans from 2019/20; these include, Promoting the uptake of Case Management Mental Health Service; Exploring evidence base for PMVA screening and update model; Increasing Workforce Flu uptake levels / Peer Immunisers and to Reduce DNAs and Cancellations.

Report Highlights from 2020/21; Covid activities and support; KPIs show Management Referrals seen within 8.9 working days, reports sent within 2.6 working days; Management Referrals reduced by 15%; Self referrals reduced to 20 from 37 last year and Nurse and Physician resource level matches demand.

DNAs and cancellations down 2%, it had been the plan to interrogate this area however Covid impacted, there are plans to undertake this going forward; Six staff engaged positively with Case Management Mental Health; Sickness Absence year average was 5.33%; Mental Health was the highest reason for absence which is mirrored in similar organisations; Flu uptake increased to 55.1%, a commendable increase from 43% the previous year; Seven Peer Immunisers this involved excellent support from the Infection Control Team and PMVA assessments reduced from 526 to 240 allowing Occupational Health to focus on other areas.

Physiotherapy referrals reduced to 96 from 133 with 28% off work as opposed to 16% the previous year; Work relatedness of Physiotherapy referrals was 3% a further reduction from 5% last year; New OH Database system implemented (COHORT); extension of the current SLA.

Future plans;

Kay Japp advised they will ask via clinical audit / customer survey – How does the service evaluate? And Are OH directing their efforts in the correct direction? They will look at; Covid-Winter planning; updated OH system which allows for data monitoring; peer immunisers and mental health support.

Members were advised that the current Service Level Agreement is in place until 31st July 2021 and has been extended until March 2022.

Management referrals have stabilised and reduced slightly (15%) from last year and the Physician and Nurse resource still match the demand.

The EASY service remains within the core OH service at no additional cost to the State Hospital. Utilisation of the Case Management (Mental Health) service remains low at 6 cases.

Across the year, sickness absence in the State Hospital averaged 5.33% which is again a reduction since 2019/20 and a significant improvement from the start of 2018 when it was 8.87%.

Mental health and musculoskeletal conditions remain the commonest disorders seen in TSH staff and mental health disorders now significantly exceed musculoskeletal as the highest cause of absence and referrals.

TSH staff Flu vaccination has seen an encouraging increase again this year to 55.1% (373) of all TSH staff received influenza vaccination in 2020/21, an increase of 12.1% from the previous year. This is a further improvement on last year which was 43% although it remains slightly below than the Scottish Government target of 60% for frontline staff. The NHS Scotland average for the same year was 39.6%.

The use of Peer Immunisers has been helpful in increasing the numbers and will be explored further for the 21/22 Flu season. Staff volunteered as Peer Immunisers and 7 were briefed by Salus staff. There was a good spread across TSH sites allowing maximum accessibility.

Following last year's recommendation, PMVA screening was reviewed and moved to a self-assessment model, which was approved by the Health, Safety and Wellbeing Committee in February 2021. PMVA screening reduced to 240 from 526 last year and is likely to reduce further this year.

Most staff accessing Physiotherapy are at work. The largest proportion of cases had spinal conditions. Waiting times were 2.19 days for appointments and average appointments per person was 2. 29 staff (30%) stated that there was a work element in their condition although only 3 said it was a direct contributor. 76% of the 96 treated, declared a positive outcome from treatment.

The Covid-19 pandemic necessitated many changes to service delivery including a significant move to telephone and video consultations and an increase in specific advice on Covid related issues including: testing; vaccinations; risk assessment; long Covid; shielding and pregnancy. There was an 88% average uptake of Covid Vaccine in TSH.

An additional piece of work caused by the pandemic was the increased need for Face Fit Testing for mask usage, and 350 staff were tested during this reporting period

Kay Japp provided a comprehensive report and presentation that was welcomed by members of the Committee.

Tom Hair thanked Kay Japp for her very comprehensive report and presentation confirming that staff-side are very supportive of Occupational Health support and the staff. Although there was discussion around the increase in absence due to Mental Health issues, Tom Hair advised that although the services available to staff are very well communicated he believes that many staff believe these services are not for them and the question should maybe be asked why not? Is it because of the environment they work in. He advised of the very good initiative that Scottish Ambulance Service ran, R U Ok? This was a Peer to Peer chat and was very well received at SAS.

An area of concern for Tom Hair was around the DNAs and hopes that work can progress into exploring the reasons. Overall Tom Hair thanked Kay Japp and the OH Team for their valued support.

Gary Jenkins echoed the thanks given for the excellent report and thanked Salus colleagues for their additional support throughout this exceptional year. He advised of the introduction of the Wellbeing Centre and the continued support that the Hospital have invested in this. During the last 12-16 months there has been a good emphasise around Wellbeing of staff and suggested it may be helpful that discussions take place with targeted surveys with staff on what barriers they may face, this could then be used as the foundation to build upon.

Cathy Fallon also thanked Kay Japp for the fulsome overview and asked; what is the cost to the Hospital for cancellations / DNAs; is there anything the Hospital can do re non-work related physio and she also commented on the issues raised in the regular reports received with the Easy system. Kay Japp was able to advise that the issues experienced with the recording of the Easy services were as a result of moving to the new system COHORT, these have since been resolved and a full report has been issued to the HR Department. The costs associated with DNAs are more of a lost opportunity cost than monetary due to the Hospital already paying for the resource. Kay Japp agreed to discuss anything additional that can be done in terms of non-work related physiotherapy.

Pam Radage thanked Kay Japp and her team for attending today and providing a detailed report and presentation.

SALUS representatives left the meeting.

STANDING ITEMS

6 ATTENDANCE MANAGEMENT REPORT

Members of the Committee received and noted the report up to 30 June 2021, as presented by John White, Director of HR and Wellbeing, who advised members that this report is very well signposted through other sources across various meetings. He advised members that the national target is 4% however following recognition of the working environment of the Hospital the target here is 5%.

The sickness absence figure from 1 June 2021 to 30 June 2021 is 7.36% with the long/short term split being 5.82% and 1.54% respectively. The total hours lost for this period is 6,838 which equates to 42.01 WTE.

The monthly absence figure has increased by 0.7% from the May 2021 figure of 6.66%. The May 2021 long/short term split was 5.35% and 1.3% respectively.

The current average rolling 12-month sickness figure is 6.64% for the period 1 July 2020 to 30 June 2021. The long/short term split is 5.50% and 1.14% retrospectively. The total hours lost for this period is 76217.17 which equates to 39.08% WTE.

The average rolling 12-month sickness absence figure represents a decrease of 0.56% when compared to the same period last year, with the average rolling absence figure from 1 July 2019 to 30 June 2020 reported at 7.20%

Members were advised of ongoing work being undertaken by Sandra Dunlop, Training and Professional Development Manager who is auditing sickness patterns. This is similar to a piece of work completed previously by RSM auditors. A report from the findings will go through the appropriate meeting channels.

John White explained that the tableau extract shown on page 12 of the report is what future reporting may look like in terms of real-time data that would inform discussion on intervention / Return to Work interviews.

There was discussion around the levels of absence in particular the long-term absence which is concerning due to the upward trend.

Gary Jenkins advised members that he is meeting with the responsible Directors to look at absence case by case. He has compiled some absence figures from across medium secure units and the prison service to allow a comparison. The figures received showed a range from 9.9% to 15.06%, and made for some very stark and interesting reading. Assurance was given to members that work continues with attendance management remaining a priority.

Members noted the report and welcomed the assurances given.

7 HR PERFORMANCE – EMPLOYEE RELATIONS ACTIVITY

Members of the Committee received and noted the Employee Relations Activity Report to 31 July 2021 as presented by John White, Director of HR and Wellbeing. John White summarised the report and rolling activity from April to July 2021. Members were advised there have been three new cases raised during July.

Gary Jenkins expressed thanks to John White and HR colleagues for their efforts in ensuring the cases are being dealt with timeously as per policies. Previously the information being reported was showing lengthy delays. The improvement in this area was noted and could also link in with work undertaken by Monica Merson and the HR Team around the PuMP Measurement and performance matrix used around targeted HR work.

Although it is good to see lower numbers being reported Cathy Fallon asked what this report

actually tells the Committee and whether this just shows the numbers involved with no detail reported. Members want to be assured that staff are being supported through these policies. It was recognised that at the November meeting, the Staff Governance return would be presented for information and this will show that the Hospital are applying the process required including any support required.

The Committee noted the report.

8 PERSONAL DEVELOPMENT PLAN REPORT

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

As at 31 July 2021:

The total number of current (i.e. live) reviews was 548 (91.2%) - an increase of 1.9% from 30 April 2021.

A total of 43 staff (7.1%) had an out-of-date PDPR (i.e. the annual review meeting is overdue) – a decrease of 1.1% from 30 April 2021.

A further 10 staff (1.7%) had not had a PDPR meeting - a decrease of 0.8% from 30 April 2021. Staff in this group are predominantly new staff with an initial set-up review meeting overdue.

Pam Radage recognised the very good achievement and commended the compliance levels reported. It was noted that the areas showing as a lower completion rate are very small departments and sickness absence of either the reviewer or reviewee can cause this. However, Sandra Dunlop advised that support and follow-up reviews are offered and carried out on an ongoing basis to those departments and or managers.

Members noted the report.

9 WHISTLEBLOWING

Members received and noted the Whistleblowing update as presented by John White, Director of HR and Wellbeing. The State Hospital have fully launched the Whistleblowing Standards and the national policy. This included testing of the Datix template and the launch of Learn-Pro modules as the foundation for staff training complimented by a targeted communications exercise.

A key requirement of the revised standards is notification of case incidence to the Board and Staff Governance Committee. This is the second report of this nature and confirms that one cases has been raised during the period 1 April 2021 to date. This case is currently subject to investigation at stage 2 within the standards. The Committee will receive the full report and any recommendations upon conclusion, following receipt at the Private Board Session.

Tom Hair asked what arrangements have been introduced for The State Hospital ‘s INWO following Brian Moore now being Board Chair. Brian Moore advised this is currently a vacancy and Scottish Public Appointments are in the process of sourcing a replacement, there has been no interim arrangement communicated at this time.

Members noted the update.

ITEMS FOR DISCUSSION

10 RECRUITMENT

Members received and noted the update and presentation provided by John White, Director of HR and Wellbeing and Monica Merson, Head of Corporate Planning and Business Support.

John White advised members that the Recruitment Policy in place is legislative and has been adopted in all other Boards. It promotes a fair and open process. There has been a recent change with the authorisation of recruitment, this will streamline the process and ensure transparency. If the position is a like for like with no changes the Executive Director can authorise however if a new post this needs approval and authorisation via the Corporate Management Team and Chief Executive. The introduction of the system JobTrain is also assisting to streamline the recruitment process, ensuring a more efficient services is provided in comparison to the old system of emails and calls. JobTrain is an interactive system and easier to navigate for all users.

Monica Merson advised members of the Performance Measurement – PuMP – Performance Measurement Process – a collaborative methodology that is as much about people and culture and mind-set as it is about meaningful numbers. Implementing PuMP Blueprint meant leading small teams through eight deliberate steps to measure and reach their own goals in alignment with the organisations strategy and purpose.

Monica Merson and her team worked with HR colleagues allowing them to pay attention to the definitions of the measure. Half way through the eight steps a virtual gallery took place allowing the HR Team to work with their stakeholders and engage and ask for feedback on the improvement ideas being shared. The feedback was then built into the next steps of the process. The methodology worked very well and HR engaged very well in the whole process. They found it extremely helpful to identify what was important in terms of data gathering.

Members noted the update and presentation.

ITEMS FOR INFORMATION

11 NHSSCOTLAND STAFF GOVERNANCE STANDARD MONITORING FRAMEWORK 2020-21

Members received and noted the update provided on the Staff Governance Monitoring Return for 2021-21. Work has already commenced to ensure the target date is met and the return is submitted prior to 24 September 2021. To date the Head of Communications, Caroline McCarron has assisted greatly with information on Well-informed, and work continues from Sandra Dunlop, Training and Professional Development Manager and her team around the Training requirement.

Linda Davidson intends on meeting with the JSS – Joint Staff Side to get assurance and input from Partnership on how the Pandemic affected our approach to partnership working. The Board have assured partnership involvement during the recovery and remobilisation.

The aim of the Staff Governance Monitoring process is two-fold. It is to provide assurance both locally and nationally that:

The Staff Governance Standards (the Standard) is being fully and properly applied in all Boards, and where there are areas for concern that support is provided; and,

It allows good practice to be shared to help drive continuous improvement across all NHS Scotland Health Boards.

From the updated return so far, questions were asked around, Modern Apprenticeship, Equality Monitoring and the Dashboard. John White advised that The State Hospital have had success in the past with Modern Apprenticeships, although limited due to the nature of the organisation. There has also previously been an initiative through the DWP and work is underway with Kick-start,

Sandra Dunlop is involved in this.

The Equality Monitoring was previously published via the website. This link will be shared with members.

The dashboard reference in the work to date forms part of the PuMP initiative and awaits further updates from the eHealth department who will work closely with the HR Team to develop.

Members acknowledged the work completed to date and look forward to receiving the completed submission.

12 APPROVED MINUTES FROM PARTNERSHIP FORUM FROM 22 JUNE 2021

Members received and noted the approved minute.

13 APPROVED MINUTES FROM HR AND WELLBEING GROUP FROM 13 JULY 2021

Members received and noted the approved minute.

ANY OTHER COMPETENT BUSINESS

14 ANY OTHER BUSINESS

Information on Project Lift; Equality Monitoring Link; PuMP slides – all to be shared with the Non-Executives who requested this information.

ACTION: J WHITE/R PRESTON

Recognition was provided to both Tom Hair and John White for their contributions to this Committee and wished them both well in their respective retirements.

15 DATE AND TIME OF NEXT MEETING

The next meeting will take place on **Thursday 18 November 2021 at 9.45am via MS Teams**.

Paper No. 21/100

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	23 December 2021
Agenda Reference:	Item No: 18
Sponsoring Director:	Finance and eHealth Director
Author(s):	Deputy Director of Finance
Title of Report:	Financial Position as at 30 November 2021
Purpose of Report:	Update on current financial position

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 (April 2021).

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. Following an initial July payment, a second sum was received in October's allocation, and we have now received settlement for Q1/Q2 and towards Q3/Q4 – for further review closer to year-end (refer to further note in 3.2).

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 (likely into 2022/23) 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 £40.701m is primarily the forecast Scottish Government Revenue Resource Limit core and non-core allocations, and anticipated additional recurring allocations.

The Board is reporting an under spend of £0.234m to 30 November 2021 (2020 - £0.302m).

PAIAW funding is now being released monthly – being is a significant element for the Board because of our high levels of overtime and high Nursing vacancies.

Recurring RRL allocations have now received in November 2021 in recognition of the settlement of B8/B9 AFC staff and the Medical (& Dental) pay increases.

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, in line with national guidance and local priorities.

Covid-19

We have received two allocations to date in June (Q1 Covid Funding 21/22 – NR) £338k. and in October ('Further general Covid funding 21/22 – N/R) £369k. A review of spend through the remaining months will determine any adjustments to these allocations towards the year-end and if there are further pressures materialising or if any release is required should the funding be in excess.

Patient Visiting

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

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 is possible for TSH in 2022/23.

PAIAW

Some pressure potentially remains re prior years still outstanding – claimants being in the hand of CLO (some of whom have recently been paid.)

Travel

As previously acknowledged, benefits have arisen due to most meetings and courses now being virtual through the Covid crisis, with future budgets being set accordingly.

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. The MSR work is scoped and the value is now known to be approx.. £400k, while the Key Safe work remains under evaluation and final costings are yet to be determined, which may create the requirement for an additional request to be raised.

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

Directorates	Annual Budget £'k	Year to Date Budget £'k	Year to date Actuals £'k	YTD Variance (budget less actuals) for period 8	Budget WTE	Actual WTE
Nursing And Ahp's	22,564	15,127	15,343	(216)	401.63	418.91
Security And Facilities	6,552	4,399	4,332	67	120.64	117.79
Medical	2,960	1,969	1,884	85	21.70	21.23
Chief Exec	1,940	1,301	1,221	80	22.07	19.46
Human Resources Directorate	938	626	612	14	14.05	14.67
Finance	2,789	1,877	1,841	36	29.02	31.36
Cap Charges	2,857	1,905	1,733	172	0.00	
Misc Income	(600)	(453)	(566)	113	0.00	0.00
Central Reserves	702	(446)	(328)	(118)	(1.00)	0.00
	40,701	**26,306**	**26,072**	**234**	**608.11**	**623.42**

Nursing and Security – see further detail below.

Medical – Underspends are noted in research (arising from delays in certain projects) and Medical Pay (changes in sessions being worked).

CE – Social Work SLA – a senior post is now recruited but awaiting confirmation. There has been structural realignment to some budgets (Corporate Services) for which adjustments are awaiting finalisation.

HR – The Learning Centre is currently underspent in corporate training, principally due to Covid.

Finance – Pay savings are noted in the Finance department and non-pay underspends in the Directorate.

Capital Charges –The budget is currently carried forward from previous year, awaiting SG confirmation of the required change to the allocation for the forecasted 2021/22 position (core to non-core adjustment). This transfer / benefit may be considered for evolving pressures.

Miscellaneous Income (MI) – The budget now recognises income received for exceptional circumstance patients, also a write-off of old balance sheet codes to MI November '21.

Central reserves – Significant reserves are for Covid, Apprenticeship Levy and AME, and any additional RRL not yet released (due to delay in projects), offset with unidentified savings.

Nursing And Ahp's	Annual Budget £'k	Year to Date Budget £'k	Year to date Actuals £'k	YTD Variance (budget less actuals) for period 8	Budget WTE	Actual WTE
Advocacy	148	99	100	(1)	0	0
AHPs & Dietetics & SLAs	716	477	369	108	13	14
Hub & Cluster Admin & Clinical Operations	864	577	495	82	25	20
NPD & Infection Control & Clin Gov	453	305	275	30	6	5
Psychology	1,388	926	959	(33)	19.50	19.48
PA's (pending NOC's)	25	25	199	(174)	0.00	5.63
PCI & Pastoral	228	152	144	8	3	4
Skye Centre	1,813	1,215	1,127	88	37	35
Ward Nursing	16,929	11,351	11,675	(324)	297	315
	22,564	**15,127**	**15,343**	**(216)**	**401.63**	**418.91**

Highlights from Nursing & AHPs: -

Ward nursing – Overtime equates to actual WTEs worked. Covid funding has now been released mid-year (September 2021) for Q1 and Q2. PAIAW funding has also been released to match costs for Q1 and Q2.

AHPs – Reflects the benefit of vacancies earlier in the year.

Hub & Cluster Admin plus PAs - There has been structural realignment to some budgets, for which adjustments are awaiting finalisation.

Security And Facilities	Annual Budget £'k	Year to Date Budget £'k	Year to date Actuals £'k	YTD Variance (budget less actuals) for period 8	Budget WTE	Actual WTE
Risk + Resilience	126	84	72	12	2.00	2.00
Facilities	4,632	3,106	2,996	110	78.87	74.49
Security	1,794	1,209	1,263	(54)	39.77	41.30
Perimeter Security	0	0	1	(1)	0.00	0.00
	6,552	**4,399**	**4,332**	**67**	**120.64**	**117.79**

Highlights from Security and Facilities: -

Risk & Resilience – Noted benefit of new start not in post from the start if the year, so providing a saving against budget.

Facilities – Housekeeping vacancies and kitchen vacancies noted, also holiday pay not fully utilised (necessitating a revision required to the future budget). Estates contracts are slightly overspent, while electricity for the year-to-date has an underspend.

Security – Some of the overtime and on-call pressures will be met from Covid funding, with Q1 and Q2 spend now budget matched Other overtime has arisen from high sickness levels.

Perimeter – adjustment is o/s to clear this balance through Capital.

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)	106	(37)
Finance	(26)	21	(5)
Nursing & AHP's	(392)	294	(98)
Human Resources	(15)	3	(12)
Medical	(20)	30	10
Security & Facilities	(215)	222	7
Unidentified (phased 1/12ths ytd)	(438)	(106)	(544)
Total	**(1,249)**	**570**	**(680)**

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.

Although unidentified is significant the budget is phased evenly over the year against monthly underspends but just not specifically matched to ledger codes.

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 and 2022/23.

5 CAPITAL RESOURCE LIMIT

The recurring capital allocation anticipated from Scottish Government for the year is £0.269m.

We are awaiting further agreed allocation, and £0.052 has been released to Capital from Revenue 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 NOVEMBER 2021	ANNUAL PLAN	YTD PLAN	YTD SPEND	under/ (over)
	£'k	£'k	£'k	£'k
PERIMETER SECURITY				
STANLEY SECURITY SOLUTIONS LTD		1,405	1,405	0
DOIG & SMITH		1	1	0
THOMSON GRAY LTD		127	127	0
TSH STAFFING APR - MAR'22		133	133	0
DJ GOODE		5	5	0
SENSTAR CORP		20	20	0
VAT RECLAIM		-55	-55	0
PERIMETER SECURITY TOTAL (Yr 1 of 2)	**2,879**	**1,636**	**1,636**	**0**
CAPITAL				
IM&T		16	16	0
OTHER		59	59	0
CAPITAL	**269**	**75**	**75**	**0**
Total CRL	**3,148**	**1,711**	**1,711**	**0**

6 RECOMMENDATION

Revenue
Year to date position is £0.234m underspend, with breakeven anticipated for the year-end.

Capital
Spend is not in even twelfths through the year, so we currently reflect funding received as matched to spend to date, with breakeven anticipated for the year-end.

The Board, and Scottish Government are asked to note the content of this report.

MONITORING FORM

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

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	23 December 2021
Agenda Reference:	Item No: 19
Sponsoring Director:	Director of Security, Resilience and Estates
Author(s):	Programme Director / Head of Estates and Facilities
Title of Report:	Perimeter Security and Enhanced Internal Security Systems Project (Public Session)
Purpose of Report:	For Noting

1. SITUATION

This report to the Board summarises the current status of the Perimeter Security and Enhanced Internal Security Systems project. Board members are asked to note the overall project update, the financial assessment and current issues under consideration by the Project Oversight Board. An additional paper is appended at appendix 1 providing a response to Scottish Procurement: Construction policy note CPN 4/2021.

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 16th December 2021 and is scheduled to meet again on 20th January 2022.

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:

Quality targets are being met, project costs are projected to overspend by a small amount (See Finance – Project Cost at point 3f below) and project timescales have been reviewed and adjusted (See “Project Timescale” at point 3e below).

b) On-site works Completed:

A revised table is presented here that gives a strategic overview of the progress of the key elements of the project:

Activity	Metric
OVERALL	
Package Workface % Complete	70%
Duration % Complete (Percentage of Overall Project Duration)	79%
Procurement	
No of approved Procurement Packages complete	24
No of Procurement Packages in progress	0
No of Procurement Packages to be commenced	0
Package Workface % Complete	100%
Duration % Complete (Percentage of Overall Procurement Duration)	91%
Detailed Design Packages	
No of approved Detailed Packages complete	26
No of Detailed Packages in progress	2
No of Detailed Packages to be commenced	0
Package Workface % Complete	96%
Duration % Complete (Percentage of Overall Design Package Duration)	95%
Cause & Effect Documents	
No of approved C&E complete	7
No of C&E in progress	1
No of C&E to be commenced	1
Package Workface % Complete	83%
Duration % Complete (Percentage of Overall C&E Documentation Duration)	98%
Construction Health & Safety Documentation	
No of approved RAMS complete	27
No of RAMS in progress	1
No of RAMS to be commenced	14
Package Workface % Complete	65%

Activity	Metric
Duration % Complete (Percentage of Overall RAMS Documentation Duration)	94%
Construction Phase - Site Works	
No of Workfaces complete	14
No of Workface in progress	7
No of Workfaces to be commenced	18
Package Workface % Complete	45%
Duration % Complete (Percentage of Overall Construction Programme Duration)	77%
Testing & Commissioning	
No of activities complete	0
No of activities in progress	0
No of activities to be commenced	27
Package Workface % Complete	0.00%
Duration % Complete (Percentage of Overall T&C Duration)	0.00%

e) Project Timescales & Quality Issues:

As previously reported, the project planned completion date moved from mid October 2021 due to the impact of COVID, delays on approval of Design Packages and Risk and Method Statements. Further programme extensions followed and another revised programme has been proposed and accepted. This projects completion in late May 2022, exceeding the contract completion date by approximately one month. 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 quotes, commitments and other adjustments such as VAT reclaim, COVID recharges and other minor changes may potentially result in an overspend (exclusive of VAT) of approximately £140k. This has increased marginally from the last Board meeting following a number of additions and subtractions to align more accurately with the revised programme and end date of 23rd May 2022.

The key project outline is:

Project Start Date:	April 2020
Planned Completion Date:	May 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):	£10,481,615
Total costs to date (Inc. VAT) at 11th December 2021:	£ 9,083,052

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 11th December 2021 is in line with the revised Stanley planned schedule of works.

Breakdown of actual spend to date –

Stanley	£ 6.606m (Certified Value, 5% retention not applied)
Thomson Gray	£ 0.655m
Doig & Smith	£ 0.008m
HVM Design	£ 0.009m
VAT	£ 1.456m
Staff Costs	£ 0.350m
	£ 9.090m

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.

Appendix 1

THE STATE HOSPITALS BOARD FOR SCOTLAND

Author(s):	Programme Director
Title of Report:	Scottish Government Construction Policy Note 4/2021
Purpose of Report:	For Noting

1 SITUATION

A Construction Policy Note (CPN 4/2021, attached as appendix 1.1) has been issued requiring contracting authorities to review and, where necessary, strengthen arrangements for inspection and assurance of work.

Appendix 1.1
Construction Policy N

2 BACKGROUND

The impact of COVID, Brexit and material supply issues are placing pressures on construction projects timescales and costs.

3 ASSESSMENT

An assessment of the requirements of CPN 04/2021 and the potential impact of the identified risks on the State Hospital project has been undertaken by the Programme Director with the assistance of Thomson Gray, Lead Advisors. A report has been prepared (Scottish Government: Scottish Procurement Construction Policy Note CPN 4/2021 28 October 2021 Assurance of Work on Site 11 November 2021) is attached as appendix 1.2. The conclusion of the report is that adequate arrangements are in place to address the issues raised in the Construction Policy Note 4/2021.

Appendix 1.2 Scottish
Government CPN 4 2(

4 RECOMMENDATION

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

Paper No. 21/102

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	23 December 2021
Agenda Reference:	Item No: 20
Sponsoring Director:	Chief Executive
Author:	Head of Corporate Planning and Business Support Clinical Effectiveness Team Leader Corporate Planning and Risk Project Support Officer
Title of Report:	Performance Report Q2 2021/2022
Purpose of Report:	To provide KPI data and information on performance management activities.

1. SITUATION

This report presents a high-level summary of organisational performance through the reporting of Key Performance Indicators (KPI's) for Q2: July - September 2021. Trend data is also provided to enable comparison with previous performance. The national standards directly relevant to the State Hospital are as follows: Psychological Therapies Waiting Times and Sickness Absence. Additional local Key Performance Indicators (KPIs) are reported to the Board and included in this report. Board planning and performance are monitored by Scottish Government through the Annual Operational Plan for 2020-21 which was submitted to Scottish Government to outline the priority areas of development.

The Board is asked to note that care continues to be delivered as outlined in the Interim Clinical Operational Policy (ICOP). This was introduced in March 2020 to ensure infection prevention and control measures are prioritized and is currently on version 23. The ICOP is supported by daily and weekly monitoring of key data to review the impact of the care model on the health and well-being of patients. This ensures that variations and trends are identified in a timely fashion and improvements made through multi-disciplinary discussion. The data gathered to inform decision making is listed below:

- Number of assaults/attempted assaults and verbal aggression
- Complaints and feedback
- Safe staffing
- Observation levels and seclusion
- Predictive data re violence and aggression
- Numbers of patients who cannot tolerate care in more isolated model
- Access to fresh air, physical activity and timetable sessions
- Participation in sessional activities such as those delivered by AHPs and Psychology.

2. BACKGROUND

Members receive quarterly updates on Key Performance Indicator (KPI) performance as well as an Annual Overview of performance and a Year-on-Year comparison each June.

3. ASSESSMENT

The following sections contain the KPI data for Q2 and highlight any areas for improvement in the next quarter through a deep dive analysis for KPI's that have miss their targets.

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

There are two KPI's which improved this quarter although not enough to change their performance zone, these are:

- Patients will be offered an annual physical health review.
- Patients will have a healthier BMI.

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

- Patients have their care and treatment plans reviewed at 6 monthly intervals.
- Patients will be offered an annual physical health review.
- Patients will have a healthier BMI.
- Sickness absence rate (National HEAT standard is 4%)

Performance Indicator	Target	RAG Q3 20/21	RAG Q4 20/21	RAG Q1 21/22	RAG Q2 21/22	Actual	Comment
Patients have their care and treatment plans reviewed at 6 monthly intervals	100%	G	A	A	A	91.06%	This indicator remains in the amber zone for quarter 2.
Patients will be engaged in psychological treatment	85%	G	G	G	G	87.31%	This indicator remains green for this quarter.
Patients will be engaged in off-hub activity centers	90%		-	-	-	-	This indicator was closed in June 2020 to accommodate engagement in off-hub activities during the pandemic.
Patients will be engaged in off-hub activity centers during COVID-19	90%	G	G	G	G	93%	This figure includes drop-in sessions which took place in hubs, grounds and the Skye Centre.
Patients will be offered an annual physical health review	90%	R	R	R	R	60.86%	Offering of annual health reviews recommenced in August 2021.
Patients will undertake 90 minutes of exercise each week	80%	A	R	G	G	86%	This indicator remains in the green zone for quarter 2.
Patients will have a healthier BMI	25%	R	R	R	R	11%	3% increase in patients with a healthier BMI in Q2.
Sickness absence rate (National HEAT standard is 4%)	** 5%	A	G	A	R	7.15%	July's figure was 7.80%, August's was 6.76% and September's was 6.91%
Staff have an approved PDR	*80%	G	G	G	G	90%	This indicator has been within the green zone since March 2019.
Patients transferred/discharged using CPA	100%	G	G	G	G	100%	3 patients were transferred during this quarter all using CPA.
Patients requiring primary care services will have access within 48 hours	*100%	G	G	G	G	100%	This indicator remains 100% in Q2.
Patients will commence psychological therapies <18 weeks from referral date	**100%	G	G	G	G	99.42%	1 patient waited beyond the specified wait time during August and September 2021.
Patients have their clinical risk assessment reviewed annually.	100%	G	A	G	G	96.83%	As at 30 September 2021, there were 117 patients in the hospital. 11 were new admissions and 3 patients had out of date risk assessments.
Attendance at CPA Reviews (Refer to Appendix 1)							

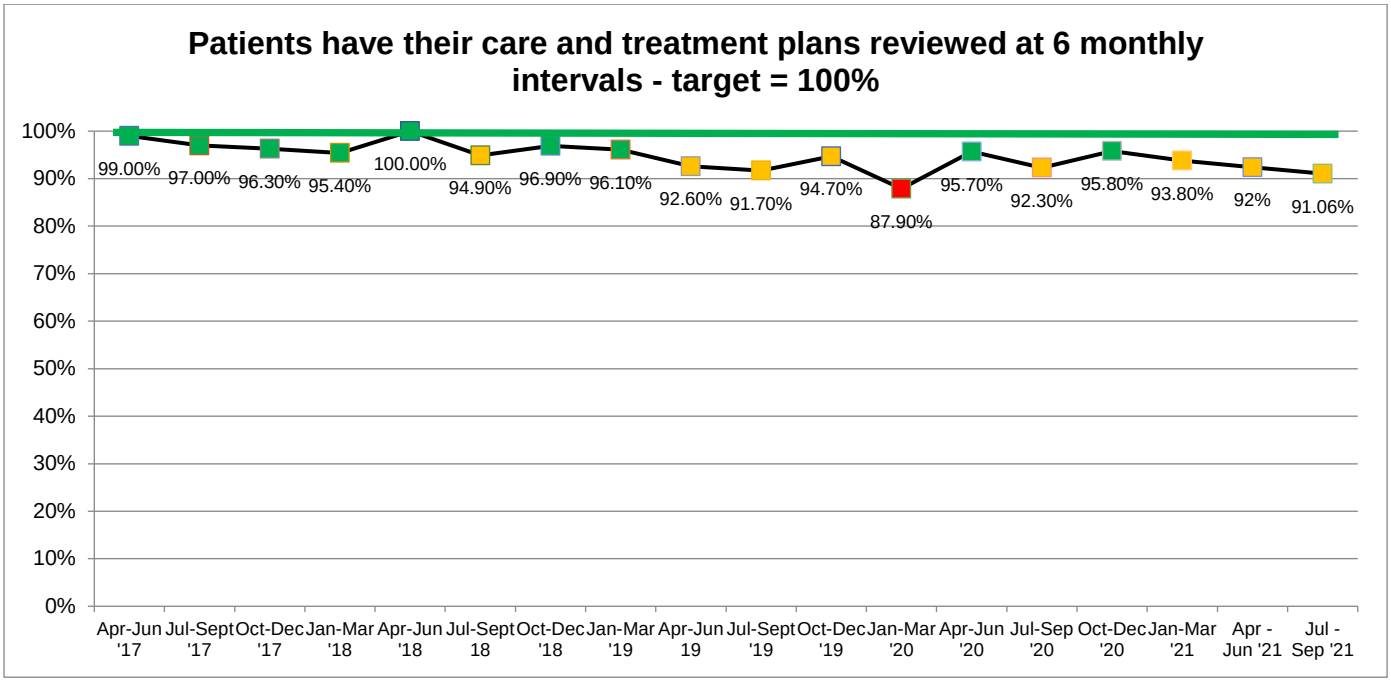
No 1: Patients Have their Care and Treatment Plans Reviewed at 6 Monthly Intervals

Target: 100%

Data for current quarter: 91.06%

Performance Zone: Amber

This is a Mental Health Act requirement for any patients within high secure settings. This indicator measures the assurance of patients receiving intermediate and annual case reviews. Care and Treatment Plans are reviewed by the multidisciplinary teams at case reviews and objectives are set for the next 6 months.



On 30 September 2021 there were 117 patients in the hospital. Seven of these patients were in the admission phase. Nine CPA documents had not been reviewed within the 6-month period, or within the agreed admission phase. All of these nine CPAs have been held with no documents being uploaded to RiO. This gives a compliance of 91.06% for quarter 2 and this indicator remains in the amber zone.

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

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

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

Health Records staff continue to send reminder emails to RMOs and medical secretarial staff to advise that a patient's review or renewal of detention is due. The renewal of detention ties in with the annual CPA document being completed.

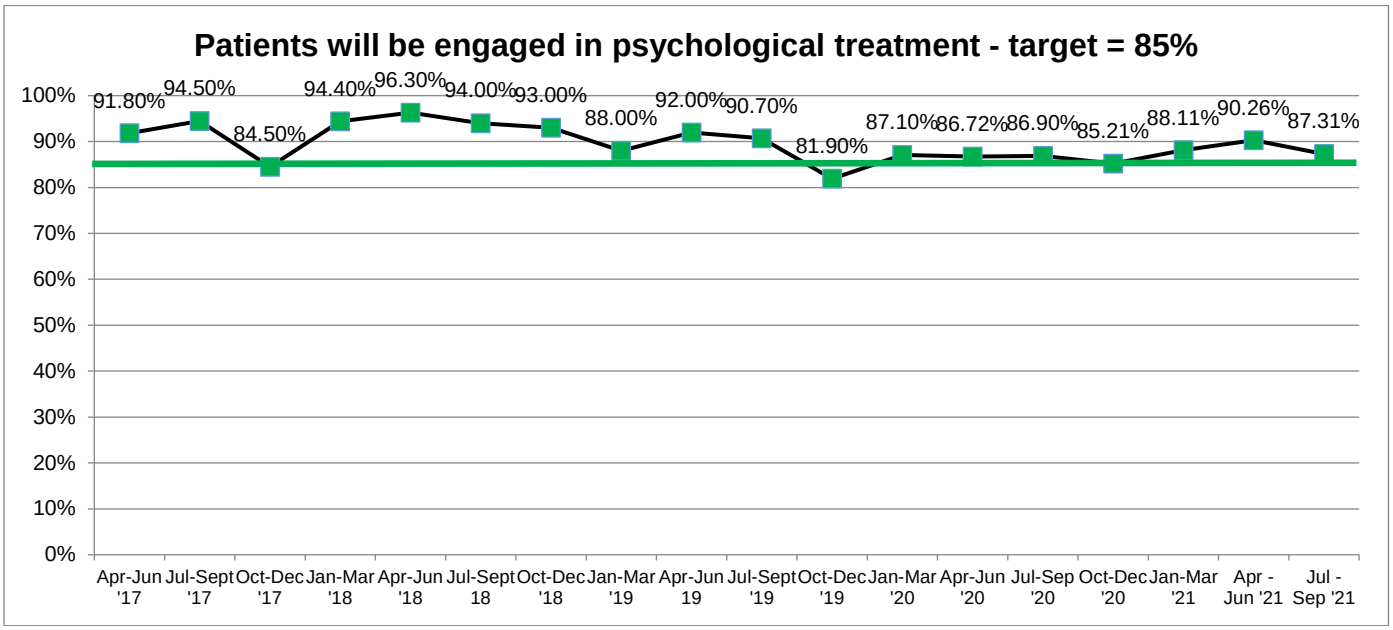
No 2: Patients will be Engaged in Psychological Treatment

Target: 85%

Data for current quarter: 87.31%

Performance Zone: Green

This indictor is a main priority of National Mental Health Indicators. This indicator measures the percentage of patients who are engaged and involved in psychological treatment.



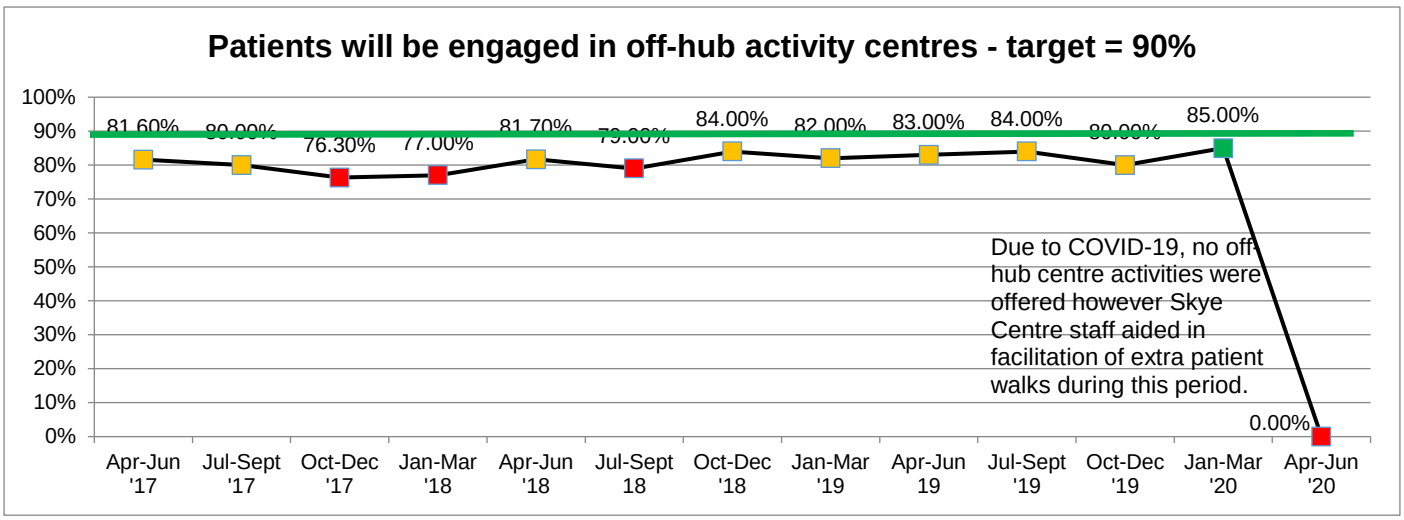
No 3: Patients will be Engaged in Off-Hub Activity Centres

Target: 90%

Data for current quarter: -

Performance Zone: -

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



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

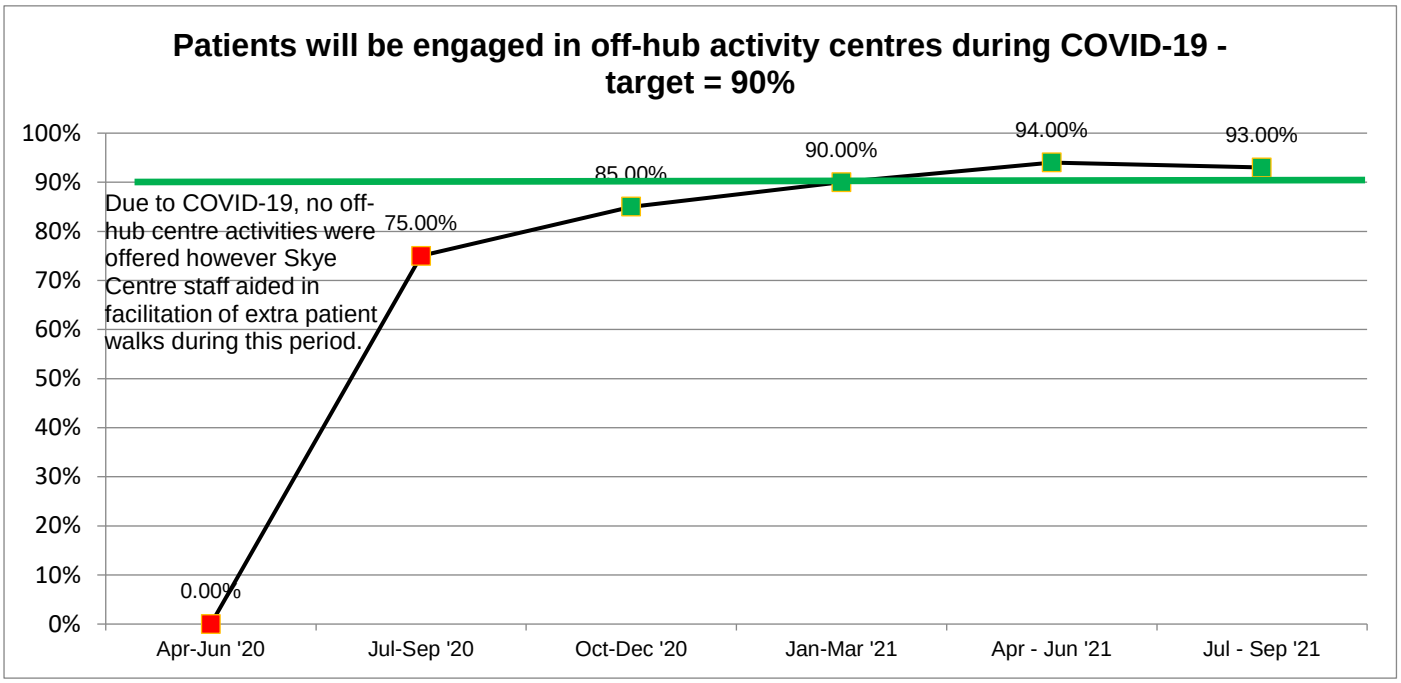
No 3.1: Patients will be Engaged in Off-Hub Activity Centers during COVID-19

Target: 90%

Data for current quarter: 93%

Performance Zone: Green

This measures the number of patients who are engaging in some form of timetable activity which takes place off their hub. The sessions may not necessarily directly relate to the objectives in their care plan however recognised as therapeutic activities. This will continue to be reported through the Operating Model Monitoring Group (OMMG).

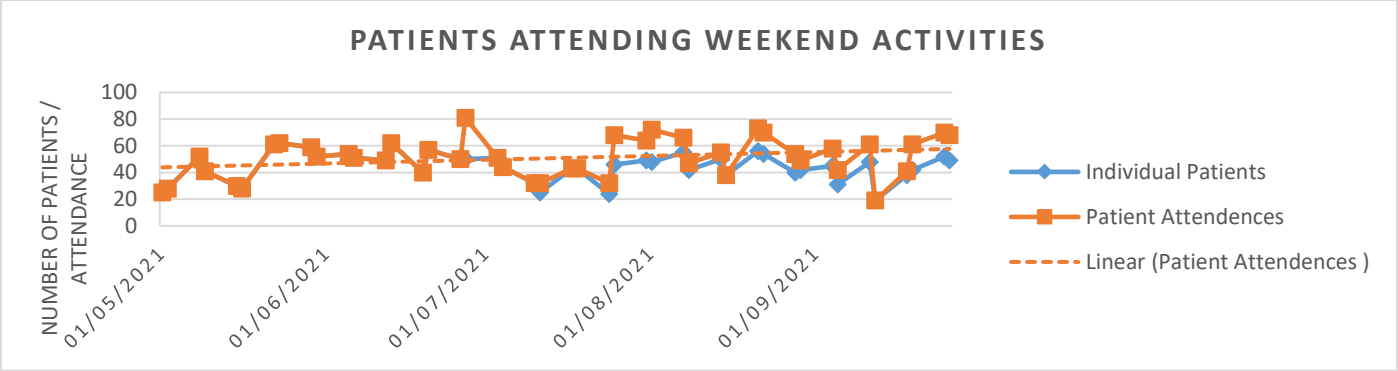


*This indicator includes data gathered pertaining to timetabled and non-timetabled sessions and drop-in rates at the Skye Centre from July 2020 onwards.

Prior to the Covid19 Pandemic the Skye Centre resource was prioritised and predominantly focused on delivering activity within the Activity Centres Monday to Friday and although some activity was provided at weekends, this was dependent on the availability of Skye Centre staffing and ward nursing support. The importance of and benefit of activity has been demonstrated by the creation of six Band 4 Rehabilitation Activity Coordinator posts. These dedicated posts are based primarily in the Hubs during the week, and are allocated to the Skye Centre at the weekend to offer activity which is accessible for patients across the hospital.

- Staffing – 6wte Activity Instructors took up post on 26 April 2021. All staff work a 5 over 7 rota.
- Monday to Friday planned group and 1:1 activity is provided on Hub/Ward and in the grounds i.e. supported walks
- Weekend group activity provided in 2 activity areas - Atrium & Sports, also 1:1 activity consistently provided for patients who require additional support.

Since May 2021, planned activities have been offered at Hub/ward level during the week and there is planned social and physical activities provided at weekends. On occasions when ward nursing deficits result in contingency plans being put in place i.e. ward closure, this staff group time has been re-prioritised and support has been provided to the ward to enable patients to remain engaged in activity. Chart 3 below shows the impact of these posts and the increasing trend in attendance.



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

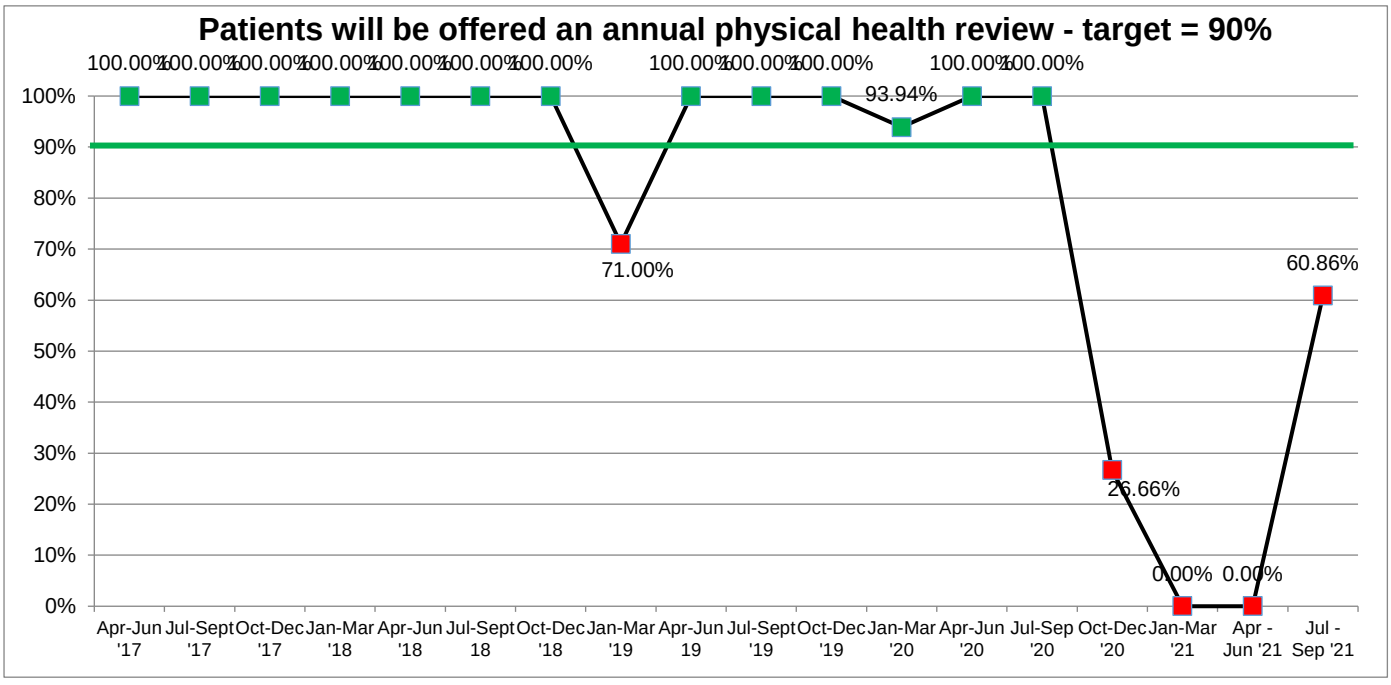
No 4: Patients will be Offered an Annual Physical Health Review

Target: 90%

Data for current quarter: 60.86%

Performance Zone: Red

This indicator is linked to the National Health and Social Care Standards produced by Healthcare Improvement Scotland (HIS). The indicator currently measures the offer of an annual health review and not the uptake. This is being reviewed to ensure that the KPI accurately captures physical health reviews carried out.



This indicator has significantly risen in Q2. A total of 23 patients were due their annual physical health review this quarter and 14 were offered this as the process of offering attendance via a letter to the patient was recommenced in August 2021.

During this period, patients were, and still are, routinely receiving their annual bloods and ECG assessments in addition to the weekly support offered from the visiting Advanced Nurse Practitioner (ANP) for patients who required more regular assessment and intervention. Any physical health issues with our patients was actioned within 48 hours via the Health Centre and liaison with Junior Doctors during this period has been vital to ensuring that any personal physical issues / needs of our patients are met. In addition, onward outpatient referrals are still being sent through the Health Centre should there be any requirement beyond TSH capabilities, in conjunction with ANP visits. Locum Doctors from the

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

Work has progressed regarding the amendment of this KPI to reflect the uptake and quality of the physical health care provided. The Practice Nurse has liaised with the high secure estates in NHS England regarding their provision and procedure of offering an annual physical health review to all their patients. The Health Centre has devised a checklist template, benchmarked against the other high secure facilities, which will be completed for every patient when their annual review is due.

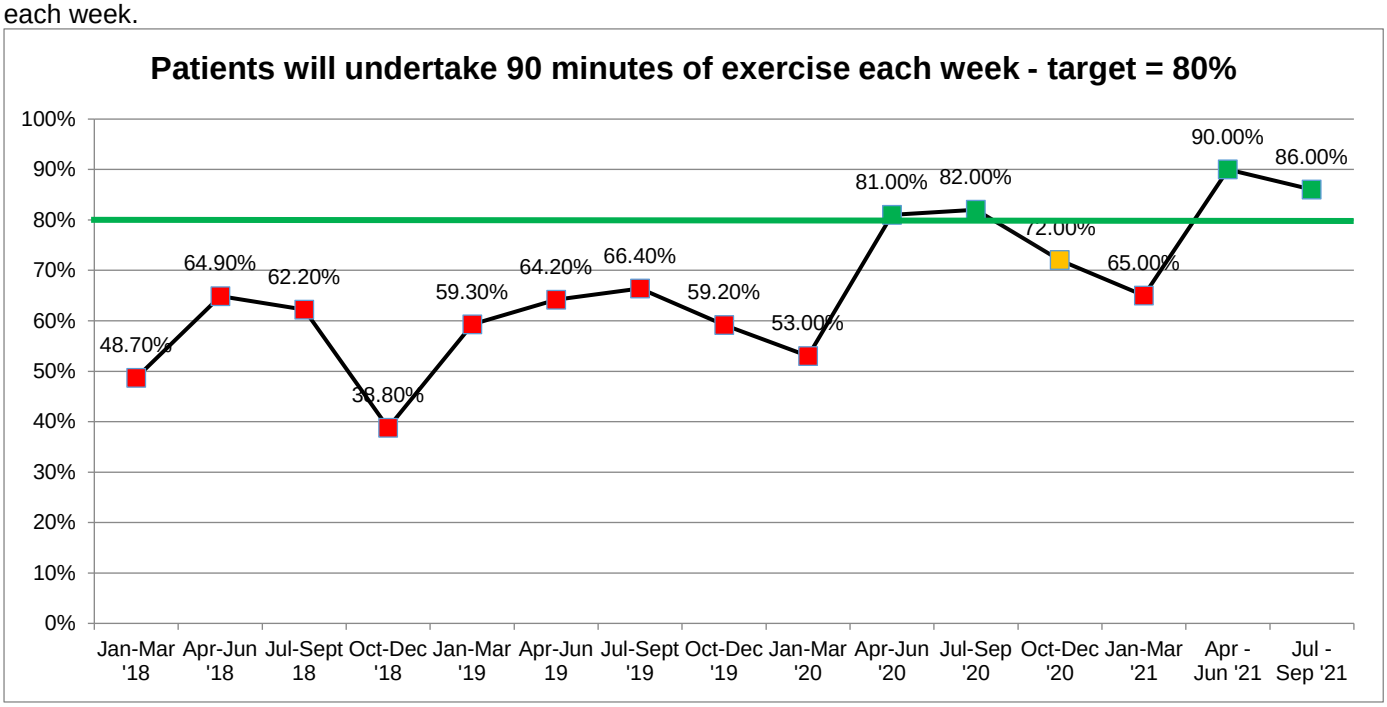
No 5: Patients will be Undertake 90 Minutes of Exercise Each Week

Target: 80%

Data for current quarter: 86%

Performance Zone: Green

This links with national activity standards for Scotland. We acknowledge that the national standard is 150 minutes per week however, 90 minutes of exercise was chosen due to this being a challenging target for the hospital with the addition of an obesity issue within the patient group. This measures the number of patients who undertake 90 minutes of exercise each week.



Data recorded is patient participation in moderate physical activity intervention. This data includes patients participating in Sports and Fitness, Gardens, ward activities and escorted walks. This data also includes patients using Ground Access as a means of physical activity. Caution should be used to the data however, as this is based on patient self-reporting. This will continue to be reported through the Operating Model Monitoring Group (OMMG). Quarterly reporting is also provided to the Physical Health Steering Group (PHSG) who review the trend data and suggest possible ways of improving the uptake of Physical Activity.

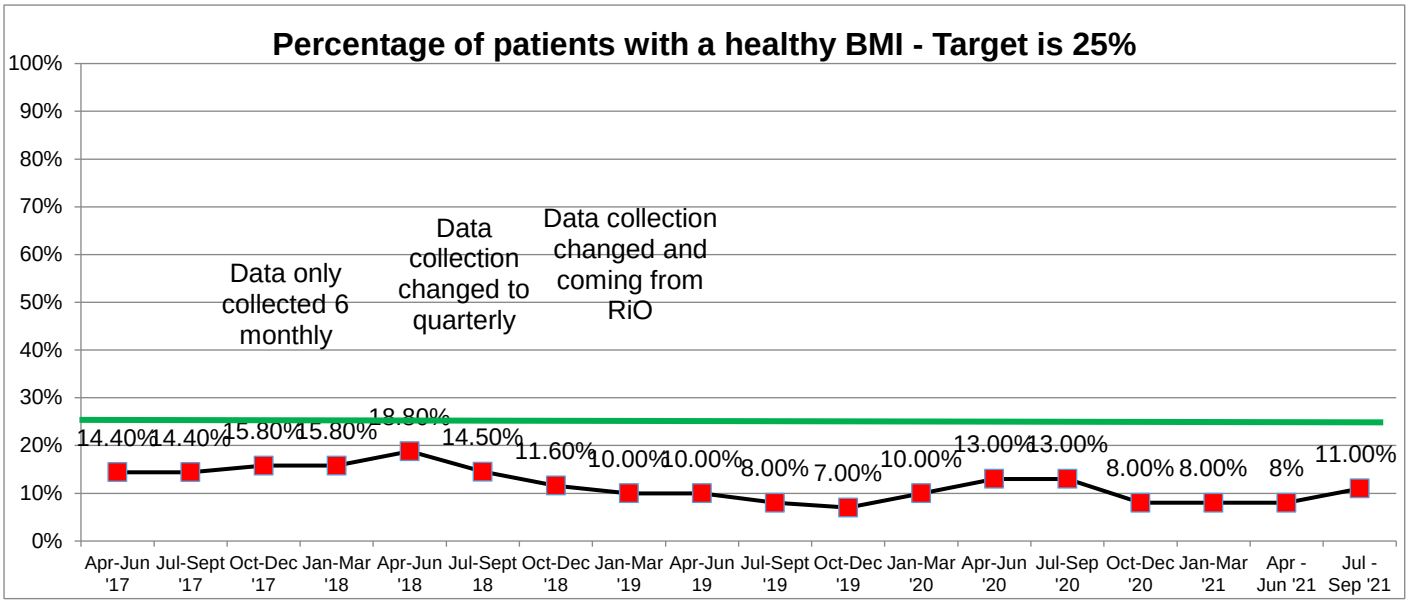
No 6: Patients will have a Healthy BMI

Target: 25%

Data for current quarter: 11%

Performance Zone: Red

This correlates towards the national target from the care standards as well as a corporate objective of TSH. This is an aspirational target and a local priority due to the obesity issue of our patient group.



The RiO reports show that 11% of patients have a healthy BMI; this is an increase from 8% in Q1. This indicator remains in the red zone. The data is a snap shot per month of the population, taken on the 12th of the month.

During this quarter, there was 27 instances where a patient had gained enough weight to move up a weight category and 12 patients who reduced in weight enough to move them down a weight category. 10 patients did not have their weights recorded in July 2021 and 2 patients refused to have their weights recorded within this quarter. In quarter 2, there was 5 admissions; 2 were within normal weight range and 3 were within the overweight range and 2 discharges who fell within the overweight range.

The PHSG have requested monthly monitoring reports to review the data and going forward, the Supporting Healthy Choices Group (SHCG) remits to change the culture in TSH for maximising physical activity and promoting healthier lifestyles; including dietary changes where appropriate. Options to consider how groups and ward-based weight loss interventions may be delivered have been included within the plan of work. The PHSG has requested monthly monitoring of Shop purchasing to ascertain the percentage of items purchased which fall in the healthy / unhealthy category and devise ways in which we can promote healthier purchases.

Weight Range BMI	**Q2 Jul-Sep 2021 N=115**	**Q1 Apr-Jun 2021 N=112**	**Q4 Jan-Mar 2021 N= 96**	**Q3 Oct - Dec 2020 N=106**
<18.5 Underweight	0%	0%	0%	0%
18.5-24.9 Healthy	11%	8%	8%	8%
25-29.9 Overweight	33%	42%	40%	35%
30-34.9 Obese (Class 1)	33%	36%	34%	38%
35-.39.9 Obese (Class 2)	15%	12%	16%	15%
>40 Obese (Class 3)	4%	3%	2%	3%

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

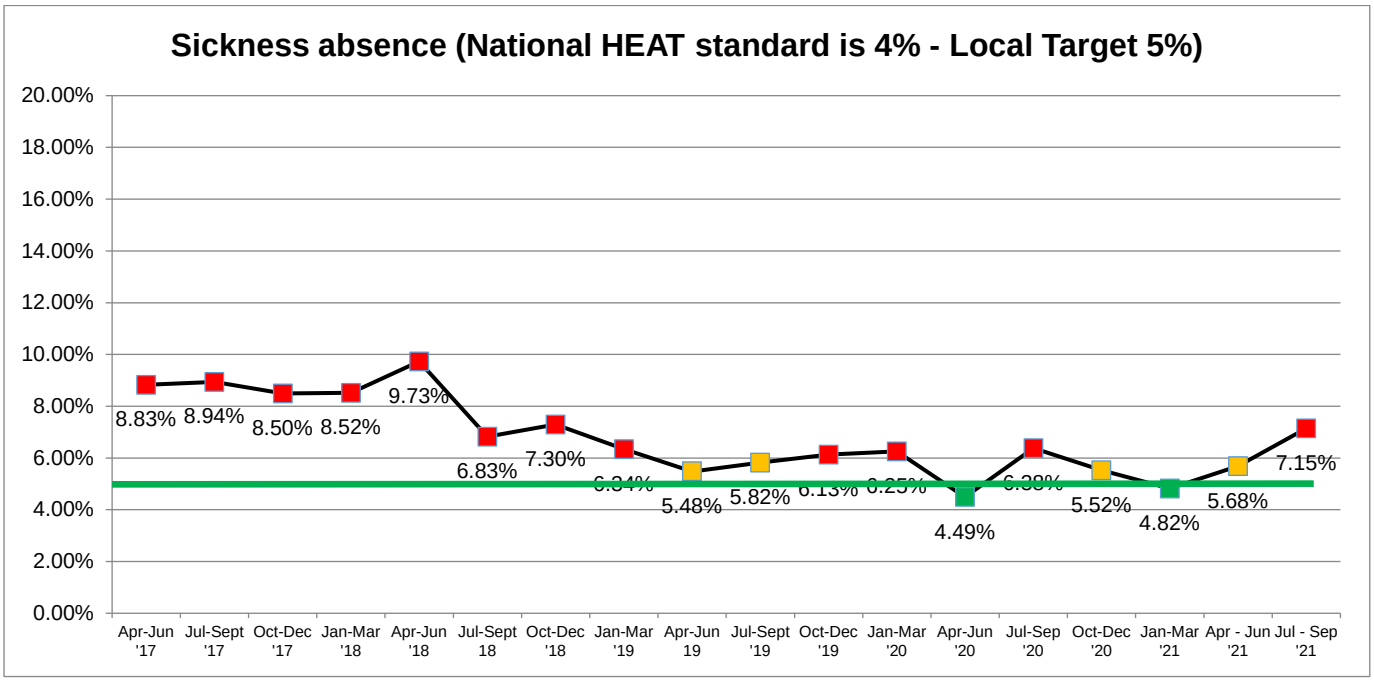
No 7: Sickness Absence (National Heat Standard is 4% - Local Standard Is 5%)

Target: 5%

Data for current quarter: 7.15%

Performance Zone: Red

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



Whilst Sickness Absence had increased, work continues on providing support to staff who are on long terms and short terms sick leave. HR Advisors are meeting with each of the Teams on a monthly basis to go over each case and provide additional support. Analysis has been undertaken with those on long term sick leave and it is clear that they are being supported by their Managers and Occupational Health. Further work is currently being done to ascertain if we need to provide additional support services in any particular key areas of concern. Anxiety / Stress and Depression continue to remain the highest reason for absence so consideration will be given to the support currently provided to staff and what the requirement is for the future.

The Health & Wellbeing agenda is also key to ensuring staff remain fit and healthy. A draft Wellbeing Strategy is currently out for consultation and this sets out the plans for the Board to support staff further with preventative solutions, where possible. The Wellbeing Advisors are working alongside staff and are speaking to them about the support and services that they would like to see and help with this moving forward.

COVID-19 RELATED SPECIAL LEAVE

It should be noted that in accordance with guidance set out in DL(2020)5 Coronavirus (Covid-19): National Arrangements for NHS Scotland Staff, staff absence and sickness related to Covid-19 is recorded as special leave and does not count towards sickness absence triggers. Details of working hours lost due to COVID-19 related special leave expressed by the monthly totals, are provided below.

Source: SSTS

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

Month	Total Hours Lost	Total Hours Lost (%)
July 2021	1545.95	1.61%
August 2021	2972.70	2.15%
September 2021	3072.11	3.27%

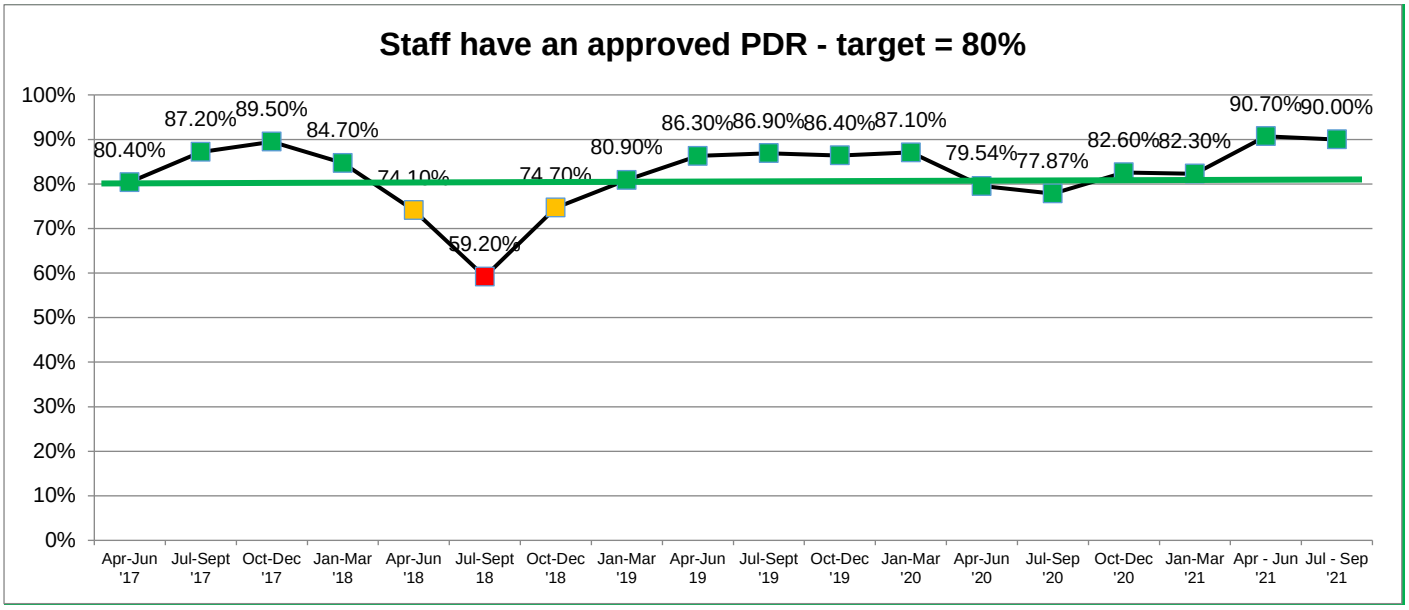
No 8: Staff have an Approved PDR

Target: 80%

Data for current quarter: 90%

Performance Zone: Green

This indicator relates to the National Workforce Standards; measuring the percentage of staff with a completed PDR within the previous 12 months.



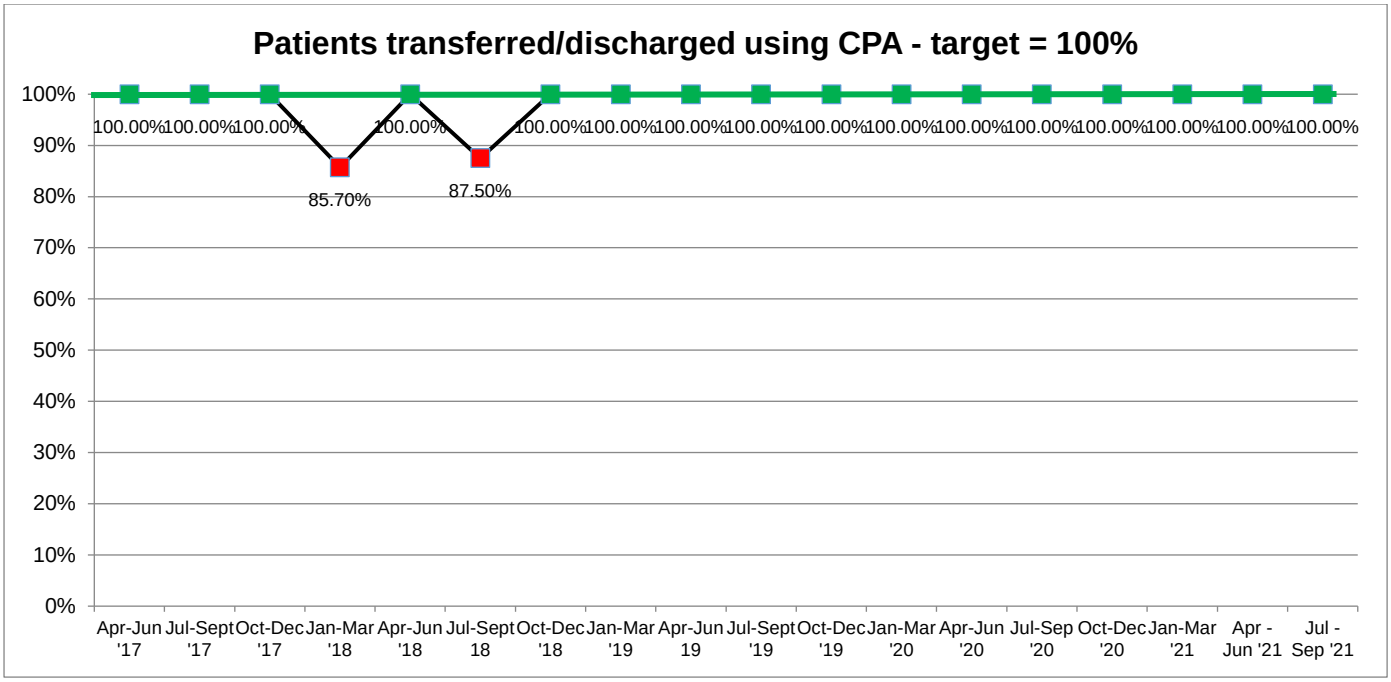
No 9: Patients are Transferred/Discharged using CPA

Target: 100%

Data for current quarter: 100%

Performance Zone: Green

The indicator is linked to the Mental Health Act, 2003 and the streamlining of discharges and transfers. The number of patients transferred out using CPA process are measured through this indicator.


Patients transferred/discharged using CPA - target = 100%
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
100.00%
100.00%
100.00%
85.70%
100.00%
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Jul-Sep '20
Oct-Dec '20
Jan-Mar '21
Apr - Jun '21
Jul - Sep '21

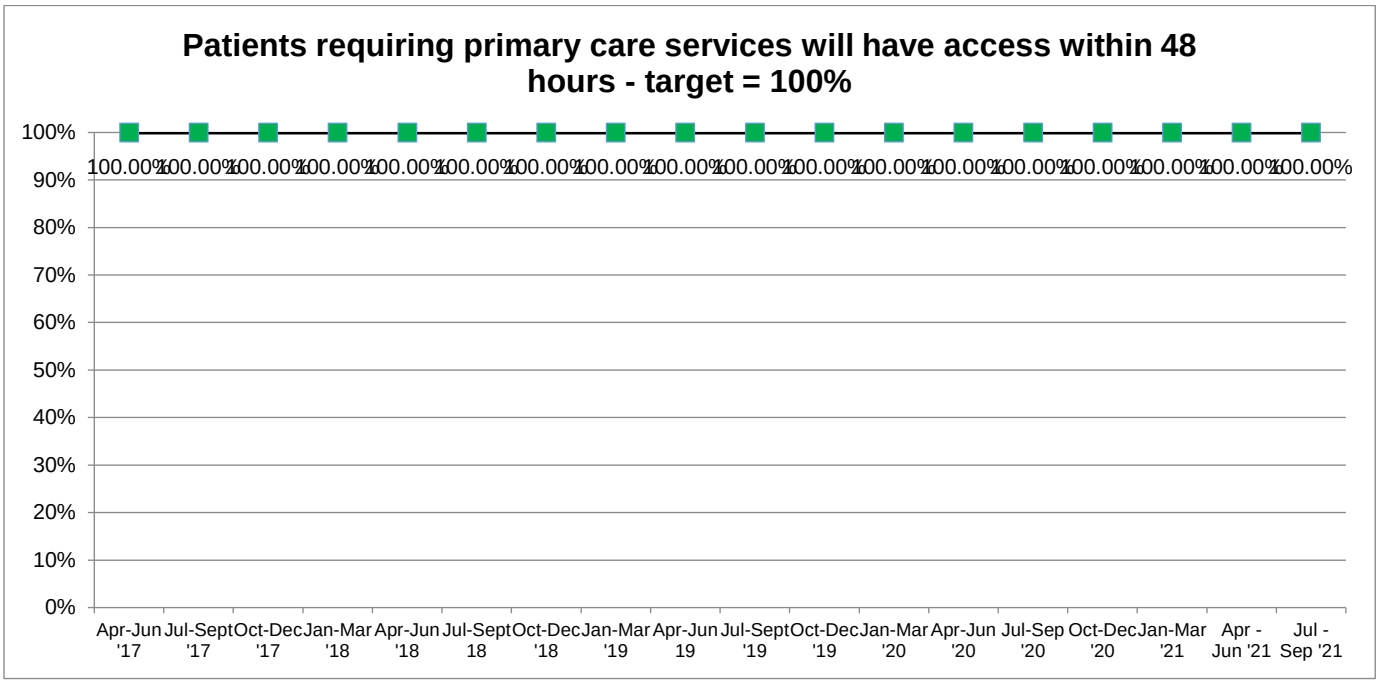
No 10: Patients Requiring Primary Care Services Will Have Access within 48 Hours

Target: 100%

Data for current quarter: 100%

Performance Zone: Green

This indicator is linked to National Health and Social Care Standards as published by Healthcare improvement Scotland (HIS). Primary care services include any service at our Health Centre including triage.



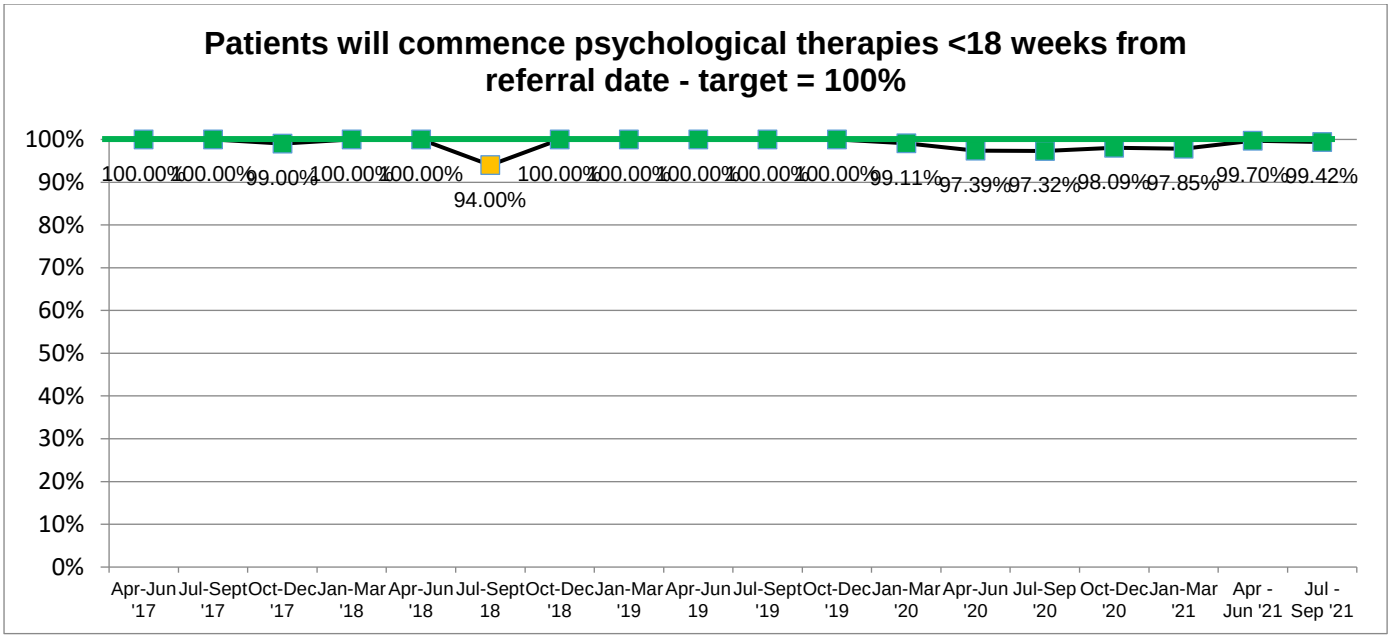
No 11: Patients will Commence Psychological Therapies <18 Weeks from Referral Date

Target: 100%

Data for current quarter: 99.42%

Performance Zone: Green

The indicator correlates to National Mental Health Indicators for Scotland to ensure that no patient waits more than 18 weeks to commence some form of psychological therapy.



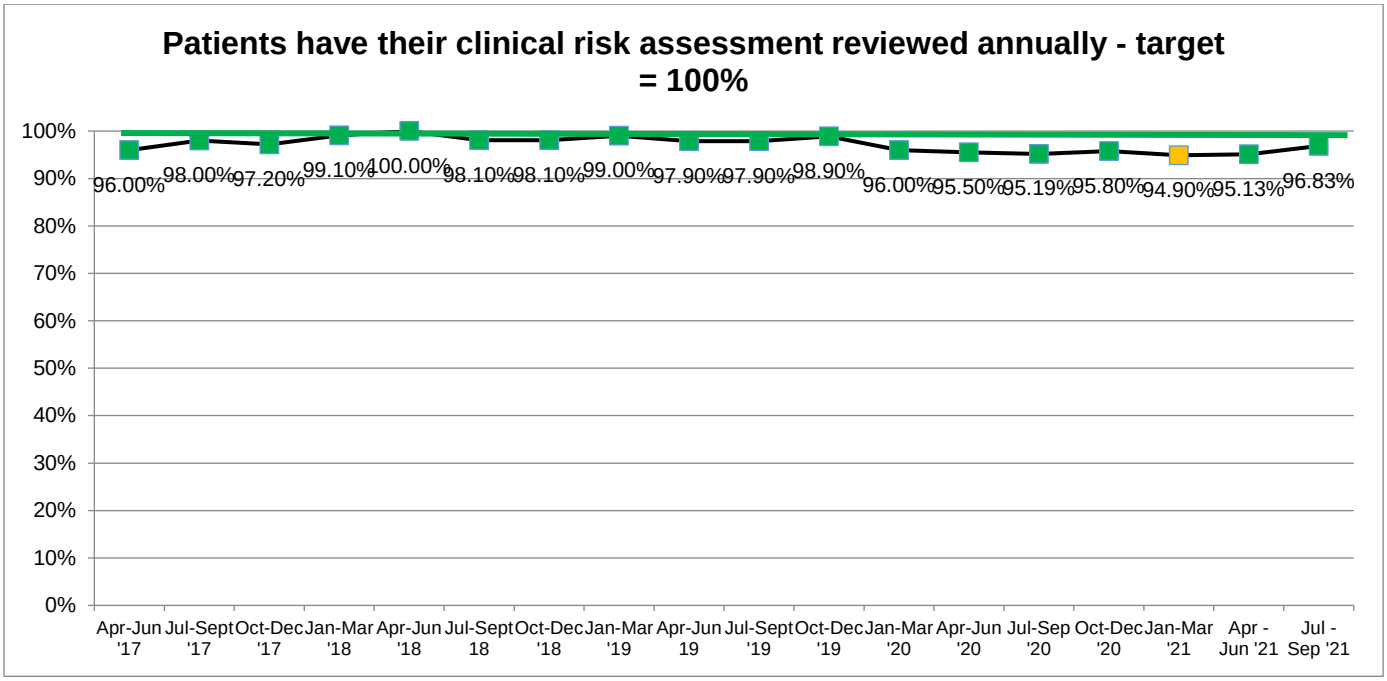
No 13: Patients have their Clinical Risk Assessment Reviewed Annually

Target: 100%

Data for current quarter: 96.83%

Performance Zone: Green

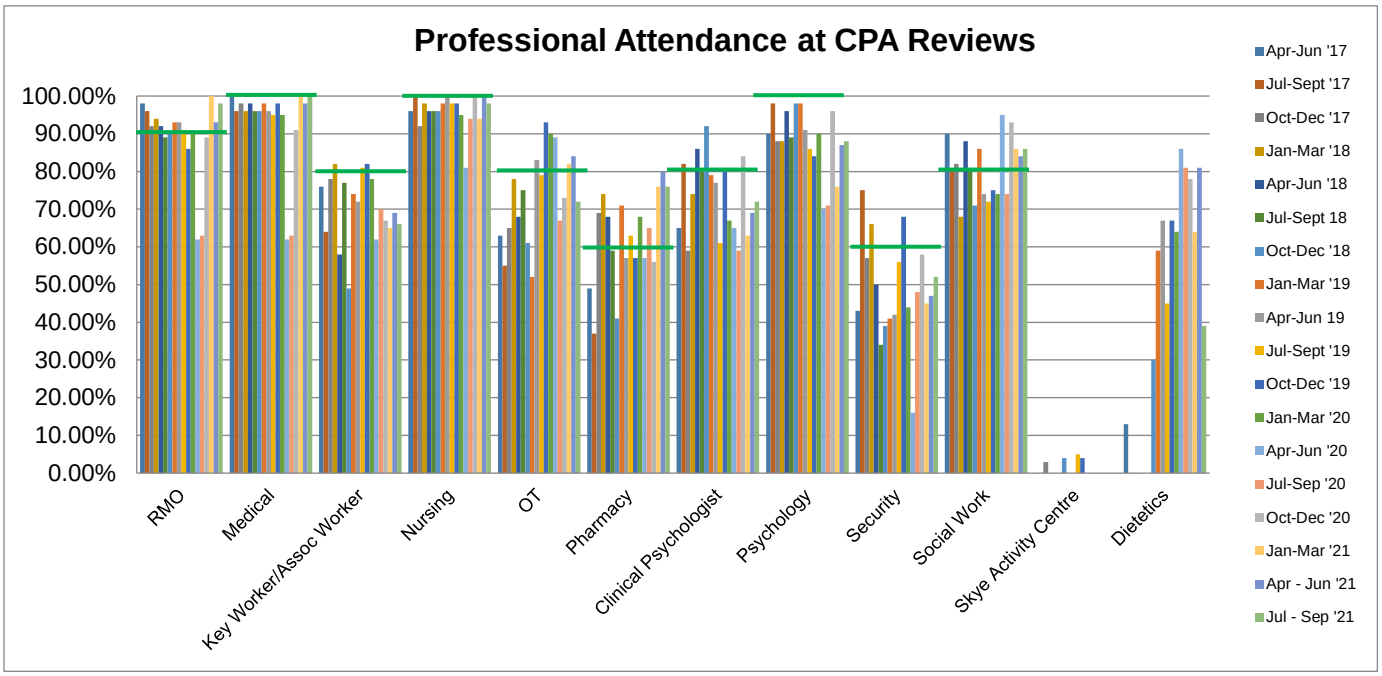
The indicator links with the Mental Health Care and Treatment Act Scotland, 2003. Examples of clinical risk assessments would be a HCR20 / SARA.



No 15: Professional Attendance at CPA Review

Target: Individual for each profession

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



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

RMO – attendance for this profession has risen to 98% in Q2. This indicator remains in the green zone.

Medical – this profession remains in the green zone for this quarter, with a rise from 98% to 100% in Q2.

Key Worker/Associate Worker – attendance figures decreased to 66% in Q2 from 69% in Q1. This profession remains within the red zone. When a Key Worker/Associate Worker was unable to attend, a nursing representative attended in their place.

Nursing – during Q2, nursing attendance dipped to 98%; this profession remains in the green zone.

OT – attendance has dropped during Q2 to 72% from 84% in Q1. OT has moved from the green zone to the amber for this quarter. This can be attributed to staff annual leave (6) and sickness leave (5).

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

Clinical Psychologists – this profession's attendance has increased in Q2 to 72%. This indicator moves from the red zone into the amber for this quarter. 6 instances where the VAT form was not completed and a combination of annual leave, staff not available and other staff attending in their place made up this percentage.

Psychology – this professions attendance has risen in Q2 to 88%. This profession remains in the red zone. On 8 occasions where the Psychologist was unable to attend, a Psychology representative attended in their place and 6 instances where the VAT form was not completed contributed to this figure.

Security - attendance from security has increased in this quarter – from 47% to 52%. Security moves from the red zone into the amber for this quarter. Staff off duty, VAT form not completed and annual leave comprises this figure.

Social Work – attendance has slightly increased in Q2 to 86% from 84%. This profession remains in the green zone.

Dietetics – during Q2, attendance from dietetics has significantly decreased to 39% from 81% in Q1. This can be attributed to staffing issues and due to one dietician leaving their post in July; this has been recruited to. There is no target for this profession as of yet.

4. RECOMMENDATION

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

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Monitoring of Key Performance Indicator Performance in the TSH Local Delivery Plan (2017-2020), the Operational Plan and the Remobilisation Plan submitted to Scottish Government in September, to cover the period September 20 – March 21.
Workforce Implications	No workforce implications - for information only.
Financial Implications	No financial implications - for information only.
Route to Board Which groups were involved in contributing to the paper and recommendations?	Corporate Management Team
Risk Assessment (Outline any significant risks and associated mitigation)	There is a dependency on the Business Intelligence project. While we can identify other ways of obtaining and analysing data there will be continue to be limitations on the timeliness and granularity of the information reported.
Assessment of Impact on Stakeholder Experience	The gaps in KPI data which make it difficult to assess.
Equality Impact Assessment	No implications identified.
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	n/a
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One √ There are no privacy implications. □ There are privacy implications, but full DPIA not needed □ There are privacy implications, full DPIA included.

Appendix 1

Item	Code	Principles	Performance Indicator	Profession (Lead)	Target	RAG Q1	RAG Q2	Overall attendance Jul – Sep 2021 (n=50)	Overall attendance Apr – Jun 2021 (n=45)	Overall attendance Jan – Mar 2021 (n=49)	Overall attendance Oct – Dec 2020 (n=45)
15	T	2, 6, 7, 9	Attendance by all clinical staff at case reviews	RMO **(LT)**	90%	G	G	98%	93%	100%	89%
				Medical **(LT)**	100%	G	G	100%	98%	100%	91%
				Key Worker/Assoc Worker **(MR)**	80%	R	R	66%	69%	65%	67%
				Nursing **(MR)**	100%	G	G	98%	100%	94%	100%
				OT**(MR)**	80%	G	A	72%	84%	82%	73%
				Pharmacy **(LT)**	60%	G	G	76%	80%	76%	56%
				Clinical Psychologist **(JM)**	80%	R	A	72%	69%	63%	84%
				Psychology **(JM)**	100%	R	R	88%	87%	76%	96%
				Security **(DW)**	60%	R	A	52%	47%	45%	58%
				Social Work **(KB)**	80%	G	G	86%	84%	86%	93%
				Skye Activity Centre **(MR)** (only attend annual reviews)	tbc			0%	0%	0%	0%
				Dietetics **(MR)** (only attend annual reviews)	tbc			39% (n=19)	81% (n=16)	64% (n=25)	78% (n=27)

Definitions for red, amber and green zone:

- For all but item 6 and 7 green is 5% or less away from target, amber is between 5.1% and 10% away from target and Red will mean we are over 10% away from target
- For item 6: 'Patients have a healthier BMI' green will be 3% or less away from target, amber will be between 3.1% and 5% away from target and red will be over 5% away from target
- For 7 'Sickness absence' green is less than 0.5% from target, amber will be between 0.51% and 1% away from target and red will be over 1% and away from target

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	23 December 2021
Agenda Reference:	Item No: 21
Sponsoring Director:	Finance and eHealth Director
Author(s):	Head of eHealth
Title of Report:	eHealth Annual Report
Purpose of Report:	For noting

1 SITUATION

In order for the Board to have an overview of the work carried out by the eHealth Department, an annual report is provided for consideration.

The eHealth Annual Report highlights the activities of the department during 2020/21 while also detailing work required for 2021/22. This includes work streams emerging from –

- Information team
- Infrastructure team
- Health Records
- Information Governance
- Project Management

2 BACKGROUND

The State Hospital's eHealth department builds on the national commitment to provide a suitable digital infrastructure for NHS Scotland, with a strong focus on delivering national initiatives and programmes. In addition, there are significant Board-specific projects which require to be addressed in order to maintain the desired level of provision for both staff and patient needs.

This report relates to the period April 2020 to March 2021 and provides an update in respect of the above work streams, in relation to contributing to the delivery of high quality service and developments based on identified needs in the short, medium and longer-terms – plus a note of priorities through 2021-22 and 2022-23.

3 ASSESSMENT

The report highlights the main areas of activity and issues from 2020-21.

Key achievements include:

- Preparation for RiO EPR upgrade;
- Tableau development / business intelligence;
- Windows 10 rollout and upgraded equipment supplied to wards;
- M365 phase 3 implementation;
- Continuation of Digital inclusion development;
- Health Records registry and policy development;
- Patient Learning Centre refresh;
- Windows 10 update.

Actions for the next twelve months include:

- Disaster Recovery Test Plans:
- Records Management Plan;
- Office 365 additional functionality;
- Patient Digital inclusion ongoing development;
- Wireless Network replacement;
- Hepma - Digital prescription system.

4 RECOMMENDATION

The Board is asked to **note** the progress outlined in the attached report for the year 2020/21 and the key plans for the coming period.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives?	The Report follows good practice and also links in with the eHealth Strategy
Workforce Implications	Not applicable
Financial Implications	No financial implications if approved
Route to the Board (Committee) Which groups were involved in contributing to the paper and recommendations?	eHealth SubGroup
Risk Assessment (Outline any significant risks and associated mitigation)	No significant risks identified
Assessment of Impact on Stakeholder Experience	None
Equality Impact Assessment	No identified implications
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	None identified
Data Protection Impact Assessment (DPIA) See IG 16.	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

eHEALTH ANNUAL REPORT

2020-2021

Responsible Director	Finance and eHealth Director
Lead Author	Head of eHealth
Contributing Authors	IM&T Senior Infrastructure Analyst & IT Security Officer
Approval Group	The State Hospitals Board for Scotland
Effective Date	April 2021
Review Date	April 2022
Responsible Officer	Finance and eHealth Director

Contents

1 Overview

With the ongoing pandemic, the Infrastructure, Medical Records and Information Governance teams have continued to have an onsite presence, necessitated by the nature of their priorities – while the Information and Project teams have continued to work more from home where possible – but all have played a significant part in all that has been achieved this year. The considerable shifting of priorities has caused the teams to refocus their direction, but eHealth staff have continued to meet these demands and provided the support needed by the Board during these unprecedented times.

The national 365 rollout, which initially consisted of email handover and Teams implementation, continues to go through development with additional work being carried out to implement some of the added features and benefits. This includes preparation work for the roll out of Phase 3 which addresses SharePoint, OneDrive and the implementation of enhanced security features such as Advanced Data Loss Prevention (ADLP), Advance Threat Protection (ATP), and Microsoft Information Protection Sensitivity Labelling and Retention. The initial rollout of email and Teams has been successfully completed and those areas are now fully supported as business as usual.

An upgrade to the EPR (Electronic Patient Record) has started with the infrastructure being built, plus testing and training starting. A lot of resources have been put in place to ensure the smooth transition between the old and new versions. This work has had a few challenges as in a major step it was agreed to upgrade to the latest version - making us one of the first boards aiming to implement it and which has seen us work closely with the vendor to resolve any issues encountered. Work is still ongoing with a go live date set in February 2022.

The rollout of Windows 10 has continued to be a focus which is nearing completion. All wards have now been migrated along with the majority of other departments. There still remains a small section of computers running Windows 7, which is currently running on extended support, but work is continuing on upgrading those and should be completed before the end of the current financial year.

The supply chain issues which started during the pandemic have continued with some equipment having an increased lead time of 6 months. This is now being managed – but reports are showing the issue will not show signs of resolving until possibly 2023. The impact of this is now being considered for all future projects to ensure any delays with equipment will not cause a delay in the process.

The future focus of the department (highlighted in section 8) will include the delivery of the national eRoster system rollout, the continuation of the Records Management plan, Implementation of the Hepma digital prescription system and the continued expansion of Digital Inclusion for patients as the Digital Transformation programme develops.

2 Information and Business Intelligence Team

The Information and Business Intelligence team continues to improve how TSH data is utilised through recording and analysis, working with a wide range of stakeholders including medics and managers to help embed data in everyday practice. Some key examples of this years' project work include:

Rio:

- Patient timetables have been redesigned and all required reporting functionality is now in place. Full rollout to users is currently being planned by HMT.
- The EPR (Electronic Patient Record) upgrade from Rio 6 to Rio 21 has been the main focus of the team's resources over the last 12 months. The project remains on schedule for a go live date of February 2022.

Tableau:

- Patient specific and anonymised, aggregated Datix Incidents dashboards have been developed and launched.
- A wide range of workforce dashboards, including additional hours, swapped shifts, a refreshed HR Attendance Report, and much more have also been launched this year.
- Significant progress has been made on a Senior Charge Nurse Assurance and Improvement dashboard, pulling live data from a wide range of sources and consolidating on one screen. UAT (User Acceptance Testing) is planned for December 2021.
- A QI project is underway to improve user confidence in the use of Tableau, and to inform how its value can be more fully realised moving forward.

3 Infrastructure Team

The Infrastructure team have continued to work towards providing capabilities and support for staff to work remotely. This has included upgrading laptops for staff who were provided with temporary equipment to support the initial drive to enable remote working.

The rollout of M365 has increased the volume and level of support required by the Infrastructure team. As with all new technologies, the Infrastructure Team had to adapt quickly to the new capabilities and functionality to be able to resolve issues or highlight to the national team areas that are of concern and provide limited support. This is a major strength of the Infrastructure team who are quick to share knowledge and collaborate on issues and resolutions.

Significant projects delivered by this team included –

Windows 10 rollout and upgraded equipment supplied to wards
M365 phase 3 implementation
RiO 21 infrastructure
Continuation of Digital inclusion for Patients

The team continue to provide regular day to day support essential to the organisation both onsite and remotely.

4 Health Records Department

The Health Records Department have continued to meet the demands placed on them, with additional temporary staffing of considerable benefit and a significant backlog of work now completed. This has allowed the department time required to move on with other longstanding projects.

Support for the Information Governance department with Freedom of Information (FOI) and Subject Access Requests (SARs) is now provided by the Heath Records Department. This support can be resource consuming with SARs at times generating the greatest volume of support work.

A formal destruction register has been created, maintaining a log of out-of-date data being destroyed. This register provides management of data destruction ensuring data protection legislation is adhered to. Advice on data management and retention has been positively received but further guidance will be distributed as this work continues.

The updated Health Records Policy and Corporate Records Policy were addressed and are now in place. Future plans include the amalgamation of these policies into an overarching Records Management Policy which will incorporate all records in the Hospital and ensure clear guidance is available for all staff.

It is planned to implement a change to the Medical Records Department. It will undergo reorganisation into an overall Records Services Department and provided support and guidance in the use and storage of both patient and corporate information. This change had been on hold through the pandemic period but is now being actively progressed.

5 Information Governance

With increasing national commitments and inter health board co-operation there continues to be challenges in maintaining the current standard of Information Governance found in the hospital. The Information Governance Group is actively addressing these challenges and work is continually on-going. Due to the necessary emphasis on this area of work, the IG Annual Report is presented as a separate document.

The effect of the pandemic continues to impact on the capacity of the Board to deliver on some of the key areas of IG, including Freedom of Information, Subject Access Requests, Environmental Information Requests and training. However, the IG team continues to adapt processes and procedures to reduce any impact on the delivery of service.

Disruption due to the pandemic has caused delay to some of the work that had been planned to be undertaken this year by the IG Team, in particular the Data Protection Compliance Toolkit and the implementation of OneTrust. This work has been slightly extended to later in this financial year to accommodate the delay.

This encompasses –

Implement OneTrust Information Asset and Assessment Platform	November 2021
Population of the Information Asset Register	January 2022
Review Information Governance Framework Toolkit and Merge with Data Protection Compliance Toolkit	March 2022
Transformation of Health Records Department in to a Records Services Department	April 2022

6 Project Management

Much of the focus this year has been on the preparation for the Rio 21 Upgrade Project. The new version of Rio will deliver a fully supported platform with additional functionality that will bring real benefits to the Hospital. The Rio 21 Project Team have delivered a modern, secure infrastructure build, configured live, test and train systems, undertaken an extensive user acceptance testing program and are now rolling out training hospital wide prior to the planned go-live in February 2022.

The national Microsoft 365 programme is now in Phase 3 which is divided into 5 Project elements – Identity Management, Data Discovery, Security and Compliance, Modern Work in Health and Modern Service Management – and M365 Project Team members have been engaging with this work. Locally, efforts have focussed on preparatory work in anticipation of the implementation of SharePoint and OneDrive. There are two SLWGs undertaking this work at present focussing on Licensing Management and Records Management and Data Cleanse.

The Senior Project Manager and Project Administrator have worked hard to deliver these projects in line with the national timescales required for M365, and the commercial constraints of the Rio 21 upgrade contract.

Other projects supported by this team included:

- Tableau dashboards rollout including Finance and SCN;
- National eRostering system programme

The Project Management Team also continue to support colleagues through the Project Approval Process – including developing the new approval flowchart and guidance – and maintaining the Project Register.

7 Post March 2021 – Key eHealth Projects 2021-2022

Storage and backup system update

The recently installed storage and backup system requires ongoing maintenance in order to ensure our digital storage solution is fully secure and supported. A reconfiguration of the storage system was undertaken and storage software was updated.

Monitoring of Uninterruptible Power Supplies

All computers systems and network switches have Uninterruptible Power Supplies. These devices have been monitored for some time but the hospital will benefit from having greater details of the UPS condition, performance and running time. This will not only help the eHealth Infrastructure department but also the Estates department.

Patient Learning Centre infrastructure refresh.

Further to much consultation with clinical staff, this was delivered in the second quarter of 2019/20. It has provided the PLC with a solution that supports up-to-date software and hardware with the capability further to expand in future as required. General IT support for the PLC was also delivered as required although this is an ongoing area for further development.

Office 365 licensing

Extensive work has been undertaken to ensure the correct level of licences are put in place going forward for all TSH staff – engaging with all line managers to address levels of access required therefrom.

8 Future Priority eHealth Projects – 2022-2023

- Disaster Recovery Test Plans:
- Records Management Plan;
- Office 365 additional functionality;
- Patient Digital inclusion ongoing development;
- Wireless Network replacement;
- Hepma - Digital prescription system.

9 Digital Inclusion

The key projects currently under development being focussed on are –

- Virtual Media Options;
- Virtual Platforms for groups – Near Me Pilot Project;
- Patient Internet Browsing Experience – now in place;
- Interactive Education Resource

Consideration is now being given to future priorities –

- Potential hand-held browsing units – security evaluation;
- Virtual Platforms – extension to clinical groups.

10 Cyber Security

Our second NIS audit took place in October 2021. This addresses the work undertaken following the recommendations of our first NIS audit last year. It is expected that our score will increase due to the changes implemented but further work will continue to be required and our focus on cyber security is now embedded as part of the everyday activities of the department. Cyber security is also the responsibility of all staff with guidance and education provided by the IT Security module on LearnPro.

We also have external 24hr monitoring of our digital traffic provided by NHS National Services Cyber Security Operations Centre (CSOC) Team. Recently they have alerted us with notifications regarding TSH staff who may have received malicious emails. The alerts are recorded and dealt with by IT Security Officer and the infrastructure team. All incidents are recorded on the Datix system and investigations are recorded. Our local onsite monitoring has also flagged up a small number of concerns but all have been successfully and safely managed.

Cyber security is a concern for all organisations and with an increase in vulnerabilities being discovered and attacks being reported within the media, this is an area that will be a constant source of discussion and requires regular support. To date there have been a few vulnerabilities that have been discovered that have had an impact worldwide which require assessments and mitigations put in place to ensure the security of the organisation's data is at a high level.

10 eHealth Collaborative Working

Collaborative working has continued to be prevalent, and has developed further over the last year. This has grown particularly with the use of Teams, with the eHealth department continuing to represent the hospital at several national eHealth groups, and work where possible with other National or Territorial Boards. We continue to have sight of national programs and projects within NHS Scotland, and benefit from national solutions wherever practical and applicable.

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

eHealth Leads Group,
National Infrastructure Group,
National IT Security Group,
National Board Digital Group,
West of Scotland Infrastructure Group,
West of Scotland IT Security Group,
Office 365 Project Group.

In conclusion, the eHealth department would also like to give thanks to all those who nominated them for the Special Recognition Award during the recent 2021 State Hospital Excellence Awards.

It was really appreciated by all of the team – thank you!

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	23 December 2021
Agenda Reference:	Item No: 22
Sponsoring Director:	Finance and eHealth Director
Author(s):	Information Governance and Data Security Officer
Title of Report:	Information Governance Annual Report
Purpose of Report:	For noting

1 SITUATION

In order for the Board to have an overview of the work carried out by Information Governance, an annual report is provided for consideration. The Annual Report highlights the activities during 2020/21.

2 BACKGROUND

The Information Governance Group, chaired by the Senior Risk Information Owner (SIRO) is responsible for progression of attainment levels in relation to Information Governance Standards – reporting to the Finance, eHealth and Audit Group.

The Caldicott Guardian principles have now been integrated within the initiatives and standards required by NHS QIS for Information Governance and attainment levels are recorded via the Information Governance Toolkit.

The Committee has, over the course of the year continued to work to improve Information Governance standards and practices across the Hospital.

3 ASSESSMENT

The report highlights the main areas of activity and issues from 2020-21.

Key areas of work addressed include:

- Information Governance Standards;
- Information Governance.Risk Assessments;
- Information Governance Training;
- Category 1 / 2 investigations;
- Personal Data Breaches;
- Electronic Patient Records;
- Information Governance Walkrounds;
- FairWarning;
- Records Management;
- Freedom of Information;
- Subject Access Requests;
- MetaCompliance;

Actions for the next twelve months include the continuance of all of the above aspects under an increasing national scrutiny and focus, plus addition work in the following areas:

- Implementation of Information Asset and Assessment Platform;
- Information Asset Register;
- IG Toolkit review and structural improvement;
- Ongoing training module development.

4 RECOMMENDATION

The Board is asked to **note** the progress outlined in the attached report for the year 2020/21 and the key plans for the coming period.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives?	The Report follows good practice and also links in with national Information Governance developments and requirements
Workforce Implications	Not applicable
Financial Implications	No financial implications
Route to the Board (Committee) Which groups were involved in contributing to the paper and recommendations?	Information Governance Group/ Finance and eHealth Group
Risk Assessment (Outline any significant risks and associated mitigation)	No significant risks identified
Assessment of Impact on Stakeholder Experience	None
Equality Impact Assessment	No identified implications
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	No identified implications
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One √ There are no privacy implications. □ There are privacy implications, but full DPIA not needed. □ There are privacy implications, full DPIA included.

THE STATE HOSPITALS BOARD FOR SCOTLAND

INFORMATION GOVERNANCE ANNUAL REPORT

APRIL 2020 – MARCH 2021

(Including Health Records)

Lead Author	Director of Finance and eHealth / Senior Information Risk Owner
Contributing Authors	Health Records Manager
	Information Governance and Data Security Officer
	Associate Medical Director / Caldicott Guardian
	Head of Risk Management
Approval Group	The State Hospitals Board for Scotland
Effective Date	April 2021
Review Date	April 2022
Responsible Officer	Director of Finance and eHealth / Senior Information Risk Owner

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1 INTRODUCTION AND HIGHLIGHTS OF THE YEAR

The Information Governance Group, chaired by the Senior Risk Information Owner (SIRO) is responsible for progression of attainment levels in relation to Information Governance Standards.

The Caldicott Guardian principles have now been integrated within the initiatives and standards required by NHS QIS for Information Governance and attainment levels are recorded via the Information Governance Toolkit. Although there is no longer a requirement to send the attainment levels to QIS or ISD, we continue to internally monitor our attainment levels biannually on this basis.

This report (formerly the Caldicott Guardian Report) is submitted on an annual basis to the Board, having replaced the previous reporting to the Clinical Governance Committee.

The Committee has, over the course of the year continued to work to improve Information Governance standards and practices across the Hospital. We have encouraged staff to adopt good Information Governance standards through a number of measures undertaken by the group, and to complete mandatory online Information Governance learning modules. We have continued to adhere to recommendations included in the Scottish Government's "NHSScotland Information Assurance Strategy CEL 26 (2011)" document and as a result a regular schedule of Information Governance Walkarounds within the Hospital – while interrupted by the restrictions required as a result of the Covid crisis – are now scheduled to resume, including non-patient areas. In addition, the group has continued to focus on other key areas of priority such as the electronic patient record (EPR) system and the outcomes of the FairWarning system – together with ad hoc issues such as record retention and email scams.

2 INFORMATION GOVERNANCE GROUP

2.1 Information Governance Group membership

Director of Finance and eHealth (Chair)
Associate Medical Director/Caldicott Guardian
Head of e-Health
Clinical Secretary Co-ordinator
Information Governance and Data Security Officer & Data Protection Officer
Senior Information Analyst & Information Technology Security Officer
Lead Nurse
Health Records Manager
Psychology Representative
Security Information Analyst
Finance Representative
Social Work Representative
Human Resources Representative
Health Centre Representative
Lead Pharmacist
AHP Representative
Risk Management Representative
Board Secretary

2.2 Role of the group

The group has a wide reaching remit, being responsible for all matters in respect of Information Governance within the Hospital as the title suggests. The membership of the group is purposely broad. This allows the group to be representative of staff groups and departments from across the hospital.

2.3 Aims and objectives

- Ensure compliance and development of Information Governance overall as monitored by the IG toolkit.
- Address issues arising in the hospital in relation to Data Protection.
- Address issues arising in the hospital in relation to Records Management including structure, filing, storage, and archiving.
- Address Caldicott issues including monitoring DATIX reports and ensuring relevant training for staff.
- Provide a forum for the various staff groups within the hospital to raise any Information Governance issues and to receive feedback from Information Governance on such matters.
- To monitor requests made in relation to Freedom of Information and Subject Access Requests.

2.4 Meeting frequency

The group has continued to meet on a quarterly basis to discuss any issues as outlined above, although some meetings were disrupted by the impact of the coronavirus. Following agreement from the wider group, a small subgroup – the Information Governance Risk Assessment Group – meets 6 monthly in order to concentrate on the assessment of the current attainment levels and supporting evidence required for the Information Governance toolkit self-assessment, which is undertaken regularly. In addition, this small subgroup also meets 6 monthly to review the Information Governance risk register (see para. 3.2).

2.5 Strategy and work plan

As noted in previous reports, the Caldicott principles have now been integrated within the initiatives and standards developed by NHS QIS for Information Governance. The Information Governance Toolkit is completed twice yearly in order to monitor the performance of the hospital in relation to Information Governance. The schedule of work for the subgroup is compiled in such a way as to allow the group to review progress with the Information Governance Standards. This monitoring allows the group to develop an action plan of work to be undertaken by the group members. In addition, meetings are used to address the issues that may arise such as filing, relevant training, confidentiality issues etc.. Next year a Data Protection Toolkit will be introduced and after an initial period of more frequent meeting the subgroup will revert to meeting on a regular six monthly basis.

2.6 Management arrangements

The Information Governance Group now reports annually to the State Hospitals Board for Scotland through the IGG Report. The IGG also reports to the Corporate Management Team as relevant.

3 KEY PIECES OF WORK UNDERTAKEN BY THE GROUP DURING THE YEAR

3.1 Information Governance Standards

In response to feedback from the Information Governance Team at ISD, following the implementation of Information Governance standards and Electronic Toolkit in 2007, the attainment levels for each of the standards were revised and new attainment levels introduced with effect from 2008.

Although the Information Governance Framework Toolkit is no longer supported nationally, the revised attainment levels within the Information Governance Framework have been agreed in partnership with NHS QIS to ensure that the Framework remains fully compliant with NHS QIS Improvement Framework

In line with Clinical Governance and Risk Management (CGRM) standards a four-point scale has been introduced that enables organisations better to demonstrate their compliance with the Information Governance Standards (IG). However, there are differences between the stages of activities required to meet each level of attainment set within the CGRM standards and IG standards, the detail of which is listed below:

Level	CGRM Activities	IG Activities
1	Development	Developing and Implementation
2	Implementation	Developed and Fully Implemented
3	Monitoring	Monitoring and Evaluation of Effectiveness
4	Reviewing	Change Implemented in light of Continuous Review Cycle

The assessment of these attainment levels is a significant part of the workload of the Information Governance Group with a focus on achieving progress against the high standard of activities set within each level. As of 2013, six additional toolkit targets were added in relation to Administrative Records, bringing the overall number to 52.

The following is a summary of the attainment levels in recent years: -

Attainment Level	2016/17 *(Includes Admin Records)*	2017/18 *Includes Admin Records)*	2018/19 *Includes Admin Records)*	2019/20 *Includes Admin Records)*	2020/21 *Includes Admin Records)*
1	3	2	2	3	3
2	3	5	1	3	2
3	1	0	4	2	1
4	45	45	45	44	46
Attainment of level 3 or better	89%	87%	94%	88%	90%

Generally, we continue to maintain our previous attainment of Information Standards as shown by our monitoring through the Information Governance Toolkit. Of the targets where attainment level 4 has not been reached, improvements in these areas will take time to achieve as some areas need negotiated with our partner organisations.

The two attainment levels sitting at level 1 relate to information sharing and information asset records. Both of these areas are expected to improve over the course of next year as with the completion of the Information Asset Registration project. This will create an information asset register as well as identify outstanding sharing agreements.

The level 2 attainments are about the hospital's procedures that manage the retention of records, Freedom of Information requests and the training of staff. These are expected to rise to

level 3 next year as work on the Records Management Plan continues. Over all we have achieved 90% in attainment levels three or four.

Next year a Data Protection Compliance Toolkit (DPCT) will be introduced as part of the Data Protection Officer's audit and monitoring of compliance with the GDPR. The Information Governance Framework Toolkit will be reviewed alongside the DPCT and it is anticipated that the two toolkits will be merged to provide a single Information Governance Toolkit for The State Hospital.

3.2 Information Governance Risk Assessments

Information Governance risks assessments are undertaken by a subgroup of the IGG – the IG Risk Assessment Group – comprising the Caldicott Guardian, Health Records Manager and Information Governance and Data Security Officer. The group first met in November 2011 to update risk assessments following the move to the current hospital site. Following on from this the subgroup has met 6 monthly to review current Information Governance risk assessments and update accordingly. The Group meets in March and September each year.

There are currently twenty-one Information Governance risk assessments on the risk register covering a variety of risks (e.g. disclosure of loss of identifiable information through transportation of records, unauthorised access to health records areas). Fourteen risks are currently at or below their target risk rating of medium, with action plans in place to reduce or eliminate the remaining seven risks.

On each occasion that the Information Governance risk assessment has been updated steps have been taken to minimise the risks highlighted (e.g. procedures to ensure identifiable information is sent recorded delivery; procedures re mobile devices; risks associated with staff leaving the organisation).

The Risk Assessment Group felt that a number of the risks held were out of date given the changes the organisation's working practices over the last few years including the use of new technologies such as Teams and remote working. It recommended that a full review of the risks held and the method of assessment would be beneficial to ensuring that risks raised through the Datix system and audits are feedback to the Information Governance risk register.

A review has been scheduled for the third quarter next year.

3.3 Information Governance Training

The "Information Governance: Essentials" module was introduced in February 2017 as an annual requirement for staff.. All modules remain mandatory for all staff. Monitoring of completion rates by staff is undertaken by the Training & Professional Development Manager, with oversight by the IGG. The completion of the modules can be seen in the table below.

Information Governance module completion

Module	Mar 2017	Mar 2018	Mar 2019	Mar 2020	Mar 2021
IG: Essentials	31%	54%	81%	70%	78%
Confidentiality	96%	97%	96%	98%	98%
Data Protection	96%	97%	96%	98%	98%
Records Management	94%	96%	95%	98%	98%

Although there have been restrictions in place over the course of the year the group was encouraged by increase in completion of the Essentials module from last year. Departments that have yet to reach the target 80% attainment for the Essentials module for an extended period are now contacted by the Data Protection Officer on behalf of the group to offer support.

Work continues with other health boards in developing NHS Scotland wide Information Governance training modules. The new course is expected to be available in the second quarter of next year.

3.4 Category 1 & 2 Investigations

There were no Category 1 or Category 2 investigations related to Information Governance during the year.

3.5 Personal Data Breaches

Under GDPR there is a requirement to record personal data breaches. In cases where there is a high risk to the individuals involved, these breaches must be reported to the Information Commissioner's Office no later than 72 hours from discovery. The State Hospital uses Datix to record potential breaches of personal data.

There were nineteen recorded personal data breaches in 2020/21. Just under half of the breaches relate to media coverage of the hospital, staff and patients, with the remaining breaches mainly due to minor accidental internal disclosures.
No breaches required notification to the Information Commissioner's Office(ICO).

Staff are encouraged to improve their Information Governance practices through guidance notes that are regularly circulated in the Staff Bulletin and feedback from incidents. The restrictions due to coronavirus have meant that there have been less opportunities for informal contact with staff to give guidance on Information Governance matters.

Reported Personal Data Breaches			
	2018/19	2019/20	2020/21
Reported Breaches	18	16	19
Required ICO Notification	2	0	0

3.6 Electronic Patient Records

Members of the IGG were actively involved in the ongoing development of the EPR (RiO) – and the project-specific EPR Group continues to meet regularly. This has included ongoing involvement in development of the business case for RiO21, providing advice on Information Governance matters and regular audits of the electronic Health Records. A business case has been agreed to move to RiO21 and a project team is in place to upgrade to RiO21.

The regular health records audits show that staff are applying high standards when making Health Record entries, and there is regular reporting on the results of these audits.

During the year as well as many other developments within RiO there has been the development of an electronic patient timetable. This development has been well received by staff. It has also allowed for the close monitoring of patients' ability to exercise, which has been particularly valuable during the Covid -19 pandemic. It has also improved Information Governance around this process. There has also been development of a system to integrate the grounds access process fully into RiO. It is hoped that this will speed up processes related to grounds access.

3.7 Information Governance Walkrounds

Having been introduced in 2015 as a recommendation following the publication of the NHS Scotland Information Assurance Strategy CEL 26 (2011) the Information Governance Walkrounds have built on the success of the previous years. The unannounced walkrounds now occur a random throughout the year and encompass all areas of the organisation were personal information is used.

Information Governance walkrounds were suspended due to coronavirus restrictions and are expected to recommence as soon as it is practical to do so.

3.8 FairWarning

The group receives exception reports on the levels of FairWarning alerts raised and a subgroup is tasked with maintaining appropriate alerts and thresholds to provide a proportionate audit of access to personal information.

FairWarning alerting rate remained consistent with last year and reflects changes in the patient population over the year. This is the fifth consecutive year in which no incidences of inappropriate access have been alerted via FairWarning.

The group have been satisfactory assured that there are no areas of concern regarding inappropriate access.

3.9 Records Management

The State Hospitals Board for Scotland submitted its Records Management Plan to the Keeper of the Records in December 2016. The Plan was agreed and accepted by the Keeper with some elements graded as amber, and having work outstanding. A Plan Update Review (PUR) was carried out in January to March 2020 which again flagged up work needing to be carried out, in particular the completion of a records survey. A further PUR will be carried out in 2021 – this will highlight the current position. There will be some negative impact from the ongoing pandemic, however there has also been some positive work, in particular around the Information Asset Register.

Records Management work is ongoing, however due to resourcing issues this has been slower than had been hoped. The Records Management Group have not met due to staff being immersed in other work, however it is hoped to have a meeting of the Group in the latter part of 2021. A programme of bulk shreds is now in place, with an excellent response to calls for shredding from various departments around the Hospital. A formal destruction register has been started, maintaining a log of data being destroyed, and also allowing management of the destruction programme ensuring data protection legislation is adhered to. Advice is being given to all departments with regard to retention of information and this is being positively received.

An update of the Health Records Policy is underway. The Administrative Records Policy will also be updated. Future plans include the amalgamation of these policies into an overarching Records Policy which will incorporate all records in the Hospital and ensure clear guidance is available for all staff.

Appraisal of patient records is ongoing with some patient records now being identified for permanent preservation whilst others have been destroyed. This work is being carried out by Health Records staff alongside the Caldicott Guardian. Discussions are ongoing with the National Records for Scotland with regard to permanent storage of records, and it should be noted that the State Hospital website is now being archived by them twice a year.

Resources within the Health Records Department have been sparse due to a variety of leave, however things are now improving with the recruitment of two new members of staff. This has allowed backlog work to be completed and forward movement is now being made with projects such as the appraisal of notes and involvement with Information Asset Register work. More

support is available to allow senior staff to be involved in hospital/national workload which will also help to improve records management within The State Hospital.

One of the main areas of work in records management is the move to Microsoft 365. This is challenging and resource-intensive, however staff are remaining positive and engaged with the move and the opportunities afforded with the use of Teams and the forthcoming introduction of SharePoint in particular.

Approval had been given for the Health Records Department to undergo a reorganisation into a Records Services Department – this has been on hold but is actively being explored. It is recognised that Records Management is an area which requires further resourcing and input, in particular in the corporate records arena.

The Health Records Manager attends national groups for Records Managers and is involved in working groups, in particular in relation to the ongoing development of guidance for Office365 and records management.

3.10 Freedom of Information

The group is kept informed of all Freedom of Information (FOI) requests and of the timescales achieved in responding to these. This year saw a continuation of the upward trend in the number of requests being made to the organisation. These have mainly come from the general public (61%), with the media and journalists (17%) the second largest requestors. The recorded numbers of requests were up 16%.

The Covid-19 restrictions have meant obtaining timely responses from across the organisation has been difficult. Access to IT systems and paper files has not always been instant and in some cases has needed to wait until personnel have been physically present on site to retrieve information. This has impacted the completion rates for FOI requests this year.

Number of Freedom of Information Requests					
	2016/17	2017/18	2018/19	2019/20	20209/21
Requests made	40	46	33	224	262
Completion rate within timescales	75%	91%	94%	100%	89%

This year has seen a rise in request for reviews, however all the reviews found that The State Hospital's original response was an appropriate response, which required no modification.

Number of Freedom of Information Reviews					
	2016/17	2017/18	2018/19	2019/20	2020/21
Requests for review made	1	0	2	0	3
Upheld without modification	1	0	2	0	3
Upheld with modification	0	0	0	0	0
Substituted a different decision	0	0	0	0	0
Reached a decision where no decision had been reached	0	0	0	0	0

This year also saw a request made to the Scottish Information Commissioner for a decision in relation to one of the FOI requests (FOI/018/20). The outcome of Decision Notice 059/201 was that The State Hospital was found to have complied with the legislation in dealing with the request.

3.10.1 Freedom of Information Self-Assessment

The FOI Committee drive a continuing improvement cycle based on the Scottish Information Commissioner's self-assessment toolkit.

The toolkit comprises of four modules which each review particular areas for our FOI obligations providing a four-point scale of performance (Unsatisfactory, adequate, good and excellent) and reviews the previous year's performance.

Public authorities, such as The State Hospital are expected to provide a minimum of 'adequate' performance, taking in to account their local setting.

Standards and Criteria	2016/17	2017/18	2018/19	2020/21
Responding on time	Unsatisfactory	Good	Good	Good
Searching for, locating and retrieving information	Unsatisfactory	Unsatisfactory	Adequate	Good
Advice and assistance	Unsatisfactory	Adequate	Adequate	Good
Publishing information	Unsatisfactory	Unsatisfactory	Adequate	Adequate
Overall	Unsatisfactory	Unsatisfactory	Adequate	Adequate

The assessment shows a continuing improve in the management of FOI requests. Further improvement in proactive publication and availability of information is reliant on The State Hospital's website being upgraded to enable searching.

3.11 Subject Access Requests

Subject access requests have returned to expected volumes this year. A noted trend this year is an increase in whole record requests from patients or their representatives. This has increased the time and resources need to provide the information.

Remote access to redaction systems has been challenging at times over the year and this has impacted the completion rates. Work is ongoing with eHealth to provide a central and remotely accessible redaction system for Information Governance.

Number of Subject Access Requests					
	2016/17	2017/18	2018/19	2019/20	2020/21
Requests made	19	13	22	49	33
Completion rate within timescales	100%	92%	94%	53%	77%

3.12 MetaCompliance

MetaCompliance is a policy management system which is designed to ensure that key policies are communicated to all members of staff in order to ensure they obtain, read and understand their content. It also provides evidence of communication to line management and can identify individual staff members as having read and understood key policies.

In November 2017 the operation of MetaCompliance transferred to Information Governance which coincided with a review of policies deployed via the system.

MetaCompliance is supported by the complimentary system MyCompliance which provides a way to acknowledge policies prior to MetaCompliance enforcing a response.

Over the last year the number of policies delivered by MetaCompliance has risen by 22% to fifty-eight. Most “All Staff” policies achieve around 80% awareness and agreement within three months of release. Whereas “Clinical” policies achieve around 85% awareness and agreement within the same timeframe.

4 IDENTIFIED ISSUES AND POTENTIAL SOLUTIONS

We have continued to try to improve attendance at the IGG meetings as full attendance at this group can sometimes be difficult to achieve – although having remote Teams meetings through the Covid crisis has encouraged a strong turnout – and we strive to encourage attendance by making the remit of the group relevant to staff members' roles, incorporating user feedback on eHealth matters into the agenda for the group. The attendance by deputies in the event of diary pressures is also now in place to encourage attendance.

The restrictions due to the coronavirus pandemic have impacted information governance and the organisation's ability to deliver Freedom of Information, Environmental Information Requests and Subject Access Requests within statutory timescales.

New technologies, such as Teams (part of Microsoft Office 365), have been introduced at pace to facilitate remote working and minimise the disruption the restrictions have brought, however the introduction of Office 365 nationally will bring additional information governance challenges as NHS Scotland migrates to a cloud based hybrid working environment.

5 FUTURE AREAS OF WORK AND POTENTIAL SERVICE DEVELOPMENTS

Due to coronavirus restrictions and an anticipated continuing disruption to the routine operation of the organisation over the course of the next year, timescales for areas of work have been set towards the end of the year.

Work/ Service Development	**Timescale**
Implement OneTrust Information Asset and Assessment Platform	November 2021
Population of the Information Asset Register	January 2022
Review Information Governance Framework Toolkit and Merge with Data Protection Compliance Toolkit	March 2022
Transformation of Health Records Department in to a Records Services Department	April 2022
Reach 80% completion for the IG: Essentials learning module.	Ongoing
Maintain 85% completion for all other IG learning module.	Ongoing

6 NEXT REVIEW DATE

April 2022

Paper No. 21/105

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	23 December 2021
Agenda Reference:	Item No. 23
Sponsoring Director:	Chief Executive
Author(s):	Head of Communications
Title of Report:	Communications Annual Report 2020/21
Purpose of Report:	For Noting

1 SITUATION

The Head of Communications is required to produce a Communications Annual Report. This report covers performance from 1 April 2020 to 31 March 2021 in support of the Communications Strategy 2015/20.

2 BACKGROUND

All communications activity supports the Board in the delivery of its core objectives and legal obligations. The establishment of a Communications Annual Report is therefore an important assurance process in considering the effectiveness of State Hospital internal and external communications.

Given the nature and organisational arrangements of the Board, patients are uniquely viewed as internal communication stakeholders in addition to Non-Executive Directors, Volunteers, the Chaplaincy Team, Advocacy and staff. Carers, the public and the media are included within external communication arrangements.

The two services predominately delivering internal and external communications are the Communications Service and the Person Centred Improvement Service (PCIS). This was an extremely busy year for both functions to keep effective and quality communication flowing.

3 ASSESSMENT

2020/21 was an unprecedented year in which the need for a united voice to communicate national and local priorities and messaging clearly to all stakeholders (and in some cases, effect behavioural change and new ways of working) was vital.

The State Hospital's Communications function and PCIS were integral all year, playing a key role in amplifying or localising national public health messaging, as well as supporting and reassuring stakeholders as they adjusted to very different ways of doing things within the Hospital or at home, e.g. remote working, video visiting.

Fast, effective and timely Covid-19 communications were achieved for all stakeholders through the Head of Communications and Person Centred Improvement Lead's rapid and flexible response to the difficult, dynamic situation of the pandemic.

Additionally:

- All core communication tasks (that could be taken forward during the pandemic including key performance indicators, quality assurance objectives and quality improvement objectives) were either progressed or completed.
- All legislative requirements were met, and all financial targets / savings were achieved.
- The communications aspect of the migration to MS O365, implementation of MS Teams and remote working was also effective and successful.

The service needs to be properly resourced to meet the current and future aspirations of the Board, the changing shape of communications as a result of the Covid-19 pandemic, new ways of working, e.g. remote / home working, developments in technology, and stakeholder preferences. Most importantly, to ensure the most effective and efficient functioning and future proofing of the Communications function through appropriate skill mix, resilience measures, and opportunities for succession planning.

Involving stakeholders, making sure that they are meaningfully engaged, is essential to the ongoing development of service delivery that supports a person centred approach where patients, carers and volunteers feel they are valued and listened to. Inevitably this calls for more regular and different communication messages and activities on numerous platforms (many new) and often delivered at pace.

4 RECOMMENDATION

The Board is invited to note the annual report and planned review of Communications resourcing going forward.

MONITORING FORM

How does the proposal support corporate strategy, objectives and policy	The Annual Report supports the State Hospital's Communications Strategy. The strategy supports legal obligations, local and national strategic objectives, quality assurance and quality improvement objectives, NHS values and behaviours, openness and transparency, professional standards, and best practice in PR and Communications.
Workforce Implications	These will be determined from a review of Communication resources.
Financial Implications	Cost associated with potential investment in staffing / resources following above review.
Route To Meeting Sponsorship and governance route	CMT/ Board Workplan
Risk Assessment (Outline any significant risks and associated mitigation)	Capacity, resilience, skill mix, and succession planning challenges identified. A review of Communication resources will help determine effective mitigation measures.
Assessment of Impact on Stakeholder Experience	Promoting key messages and a positive image of the Hospital leads to improved public understanding of the Hospital and mental illness, and helps tackle associated stigma.
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).	The Head of Communications works closely with the Person Centred Improvement Lead to support an inclusive approach to ensuring patients who experience significant barriers to communication are enabled to contribute meaningfully to all aspects of care and treatment.
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.

COMMUNICATIONS ANNUAL REPORT 2020/21

THE STATE HOSPITALS BOARD FOR SCOTLAND

1. CORE PURPOSE

Effective communications play a key role in how all stakeholders perceive the State Hospital.

The core purpose relates to all aspects of communications both internally and externally - from consultancy / advice and guidance, to the provision of electronic communications, dealing with the media, and the production of corporate publications. In particular, the Head of Communications acts as a communications link between the Hospital and stakeholders including staff, the local community, general public, professional bodies, and local and national government, and drives forward improvements in communication. This enables the influencing and shaping of communication planning and strategy at all levels, ensuring good communications practice is firmly embedded in everyday service development, delivery and change.

Given the nature and organisational arrangements of the Board, patients are uniquely viewed as internal communication stakeholders in addition to Non-Executive Directors, Volunteers, the Chaplaincy Team, Advocacy and staff. Carers, the public and the media are included within external communication arrangements. This is where communications differ from that of other Boards. The State Hospital's general public (patients) are long stay and therefore are classed as internal stakeholders. The general public as a whole are potential patients of territorial Boards and are viewed by them as external stakeholders. These Boards will therefore undertake direct engagement with their general public in relation to health, wellbeing and services provided.

The two services predominately delivering internal and external communications within the State Hospital are the Communications Service and the Person Centred Improvement Service (PCIS). Key results areas include: Stakeholder Communications (Internal and External including staff, patients, carers and volunteers), Public Relations (Relationship Management), Crisis Management, Public Affairs (Media and Political) and Marketing Communications.

2. LOCAL AND NATIONAL DRIVERS

Communications is delivered in line with the State Hospital's Corporate Communications Strategy which meets the legal obligations contained within:

- The State Hospital Annual Operating Plan 2019/20.
- Remobilisation Plan.
- National Staff Governance Standard (4th edition), June 2012.
- NHS Scotland Healthcare Quality Strategy, May 2010.
- NHS Scotland 2020 Workforce Vision (*Everyone Matters*), June 2013.
- Healthcare Improvement Scotland (HIS) – 'What Matters To You?' August 2016.
- Human Rights Act 1998.
- Public Interest Disclosure Act 1999.
- Freedom of Information (Scotland) Act 2002.
- Equality Act 2010.
- Public Services Reform (Scotland) Act 2010.
- Patient Rights (Scotland) Act 2011.

- Mental Health (Care and Treatment) (Scotland) Act 2003 / 2015.
- Carers (Scotland) Act 2016.
- Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016.
- General Data Protection Regulations (GDPR) 2018.
- Duty of Candour Procedure (Scotland) Regulations 2018.
- Fairer Scotland Duty 2018.

The Board's Corporate Communications Strategy 2015/20 focuses on internal and external communications. It supports the aspirations of the Board and is regularly reviewed in a collaborative manner in line with effective partnership working practices, and best practice in involvement, engagement and consultation processes.

This strategy was due for review during the height of the Covid-19 pandemic but was paused until 2020/21 to allow for a better understanding of what the 'new normal' for communications would look like. For example, communication technology has advanced and changed at pace in response to the Covid-19 pandemic, so there is a need to ensure the Hospital's strategy can be adapted to changing audiences, technologies and media platforms as well as being deliverable within the current resource. It is acknowledged that communication trends are changing based on advances in technology, shifts in marketing methods, and audience engagement and these trends will likely play a big role in the future of communications for organisations worldwide: the fine-tuning of content marketing by PR specialists, live video, and the evolution of social media marketing. For the State Hospital these translate into mental health awareness raising and utilising social media. To date, the Board has been cautious around interactions with the media (primarily taking a reactive approach) and has not approved social media as a formal channel of communication.

The Media Policy & Procedure, Website Maintenance & Development Policy and other relevant documentation support the Corporate Communications Strategy including the discrete Pandemic Influenza Communications Strategy which was updated for 2020/25 during the year.

3. COLLABORATIVE WORKING

A key aspect of the Communications function is the requirement for effective and regular collaborative working across all directorate structures and teams. Being independent from other functions, services or directorates, ensures effective broader organisational confidence, dialogue and connection is maintained. This is something that has been achieved over many years. Within the State Hospital environment, it is important for staff to be able to see a function that not only serves all staff and disciplines equally, but is positioned correctly to do this through a joined up internal network of strong lines / links in all directions with communications in the centre.

Collaborative working with the Scottish Government Mental Health Team and Communications colleagues was stepped up during the pandemic. The Head of Communications represented the Hospital at twice weekly Scottish Government communication meetings attended by NHS Scotland health and social care communications peers. These vital meetings ensured 'hot off the press' information from a credible source, the opportunity for collaborative working between organisations where appropriate, facilitated question and answer slots, and enabled a unified voice to communicate national priorities, messaging, campaigns and links to further information / resources to NHS Scotland staff and the people of Scotland.

4. STAFFING / RESOURCES AND INVESTMENT FOR THE FUTURE

The role of the Communications function is to provide a communications service to the whole of the Hospital to help it meet its commitment to openness and transparency. This is done through a wide range of communications activities and vehicles to support the Board in meeting the diverse needs of its stakeholders.

The Communications function comprises just one post – Head of Communications – who was awarded the 'Chartered PR Practitioner' status during the year from the Chartered Institute of Public Relations. Throughout 2020/21 the post was aligned to the Covid-19 response. Concurrently, other key priorities related to supporting the Hospital's migration to Office 365, implementation of Microsoft Teams, and the work of the Recovery and Innovation Group. These time consuming commitments created additional workload.

A Communications Staffing Recruitment Proposal was produced by the Head of Communications in July 2020 highlighting the need for dedicated Communications support. Subsequently, the service was pleased to secure a graduate placement from the Glasgow Centre for Inclusive Living. The post commenced in January 2021 for a fixed-term of two years with the expectation that the placement would bring joint benefits. However, the individual resigned following induction and before any work could be undertaken. This was regrettable as the Head of Communications had invested considerable time training and providing support.

Consideration needs to be given to a resource review of the Communications function to meet current and future aspirations of the Board, and the changing shape of communications. To ensure the most effective and efficient functioning and future proofing of the Communications function, this may require the recruitment of a full time individual with specialist skills in communications, PR, media / new media, and audio visual required for the role. Someone who can bring new and different skills to the function that will complement the skills of the Head of Communications; a strategic thinker who has extensive experience of engaging with stakeholders on numerous social media platforms with proficiency in developing and delivering media and social media content and campaigns, producing audio visual content, using graphic design packages, and employing various design and print processes.

An alternative approach may be to align this function collaboratively with another NHS Board as part of a collaboration. The future is digital and it is vital that the function has these specialist skills to effectively and meaningfully operate in the digital and social media world.

5. KEY PERFORMANCE INDICATORS (KPIs)

Established KPIs relate to the core Communications function as detailed below:

No	KPI	Source	Timescale	Status / Outcome
01	To produce a Communications Annual Report for presenting to the Board.	Board	Annually	**Continues to be met**
02	To produce the Board's Annual Report.	Board	By 31 October each year	**Continues to be met**
03	To produce at least 44 weekly bulletins for staff.	CEO	By end March 2021	**Complete** A total of 52 were produced.
04	To produce at least 40 special bulletins as a support to staff.	CEO	By end March 2021	**Complete** A total of 264 were produced. Of these, 213 related to Covid-19 and 51 were dedicated bulletins.
05	To produce Staff Newsletter 'Vision' twice a year as a minimum.	CEO	By end March 2021	**Complete** Only one edition (December 2020) was produced in year due to Covid-19 pressures.
06	To deliver on 100% of all appropriate requests for Talks to the Community.	General Public	By end March 2021	**N/A** No requests for general State Hospital presentations were made due to the Covid-19 pandemic.
07	To respond to 100% of urgent Media Enquiries within the timescale requested and within one working day.	Media	By end March 2021	**Complete** There were 28 media enquiries.
08	Meet the requirements of the 'Well Informed' Staff Governance Standard.	Staff Governance Standard	March / April 2021	**Complete** Achieved and evidenced by way of the 'Well Informed' section of the State Hospital's Staff Governance Standard Monitoring Return.
09	To ensure attendance at four of the six State Hospital Board Meetings.	Board	Annually	**Continues to be met**
10	Ensure Board business is published on the Website. This includes: Board Meeting Dates, Public Notices, Agendas, Minutes & Papers.	Board	Ongoing	**Continues to be met** Additionally, after each Board Meeting a review all Board papers takes place to identify information / communication for the staff bulletin, staff newsletter 'Vision', Intranet, Website and Media as appropriate.

No	KPI	Source	Timescale	Status / Outcome
11	To attend 90% of NHS Scotland Strategic Communications Network Meetings.	NHS Scotland	By end March 2021	**Continues to be met** These meetings were held by Teams twice weekly during the year as part of Covid-19 management.
12	To ensure representation at the annual NHS Scotland Event.	NHS Scotland	Annually in June	**N/A** There was no event in 2020/21 due to the Covid-19 pandemic. The event in June 2021 will be virtual.
13	Annual re-design of Weekly Staff Bulletin and Special Bulletin.	Chairperson	By end March annually	**Continues to be met** Additionally, two header designs for Covid-19 bulletins were developed: an initial design at the outset to distinguish Covid-19 bulletins from other bulletins, which was superseded in year by a header that was more reflective of progress towards recovery.

The table below details activity not covered by KPIs:

No	Workstream	Lead	Outcome	Key Result Area
01	Media Releases	Head of Comms	One Media Release was issued in November 2020 entitled 'State Hospital Wins Psychiatric Quality Improvement Team of the Year Award'.	Media Relations
02	Media Features	Head of Comms	No Media Features were produced in 2020/21.	Media Relations
03	Media Leaks	Head of Comms	Three were eight reported through Datix.	Media Relations
04	FOI Enquiries	FOI Lead	A total of 262 enquiries were responded to. Of these, there were six separate FOI Media requests that asked 19 questions. Note! Every distinct question is recorded as a request rather than each applicant's request.	Public Relations
05	Academic Published Articles	Research & Development Manager	The Research Committee Annual Report 2020/21 notes 15 published journal articles and the delivery of 10 presentations.	Public Relations

No	Workstream	Lead	Outcome	Key Result Area
06	Continue to invite visitors to the Hospital to learn about the Hospital's work. Visitors include MSPs, Health Board Chairs and senior officials as well as other stakeholders.	Executive Team	Ongoing annually as outlined in the Chief Executive's Report to each Board Meeting.	Public Relations
07	Patient Updates	Person Centred Improvement Nurses (PCIN)	Regular patient updates are provided throughout the year, including tailored versions for patients who require adapted formats.	Patient Relations
08	Carer Updates	Person Centred Improvement Advisor (PCIA)	Specific, targeted Carer Updates, e.g. service delivery, safety and security, infection control are produced as required.	Carer Relations
09	Carer Events	PCIA	Information about social events is shared with carers who have consented to receiving same.	Carer Relations
10	Volunteer Updates	PCIA	Dedicated volunteer updates are produced as required, in addition to sharing the Staff Bulletin and other relevant information with volunteers who have consented to receive same.	Volunteer Relations
11	Networking: Presentations / Workshops / Seminars	Person Centred Improvement Lead (PCIL)	To share best practice, address stigma and respond to national drivers on a range of topics including 'What Matters To You?', Triangle of Care, Volunteering impact, and Augmentative Communication. Creative feedback methods are adopted to support those with communication barriers to engage in Person Centred Quality Improvement initiatives including person centred visiting and the equality agenda, e.g. Protected Characteristic Groups, Equality Outcomes and Equality Impact Assessments.	External Networking
12	Stakeholder Stories	PCIL	Present feedback from patients, carers and volunteers regularly directly to the Board.	Board Awareness
13	Leadership Walkrounds	Executive Team	None took place in 2020/21 due to the Covid-19 pandemic.	Staff Relations and Patient Engagement

6. QUALITY ASSURANCE (QA) OBJECTIVES

The table below details progress against QA objectives set for 2020/21:

No	QA Objective	Source	Lead	Timescale	Status / New Timescale
		Internal Communications			
01	Annual review and update of all Person Centred Improvement Service text on the State Hospital Intranet.	Person Centred Improvement Steering Group (PCISG)	PCIL	Annually	**Continues to be met**
02	Review the operating effectiveness of the Intranet for staff with a focus on content and the current document management system (i.e. Sharepoint).	Executive Team	Head of eHealth	Ongoing	SharePoint will move to the Cloud via Office 365, and will mitigate the risk associated with the current SharePoint installation. This will also remove the need for financial investment to upgrade SharePoint on site as SharePoint is part of the O365 deployment that has been negotiated nationally with Microsoft and NHS National Services Scotland (NSS).
03	Review and update publications (as appropriate) in the Hospital's Publications Database.	Comms	Head of Comms	Ongoing	**Continues to be met**
		External Communications			
04	Annual review and update of all Person Centred Improvement Service publications.	PCISG	PCIL	Annually	**Continues to be met**
05	Undertake an annual review and update of the content on the Website.	Comms	Head of Comms	By August each year	**Continues to be met**
06	Annual review and update of all Person Centred Improvement Service text on the State Hospital Website.	PCISG	PCIL	Annually	**Continues to be met**

No	QA Objective	Source	Lead	Timescale	Status / New Timescale
			External Communications		
07	Production of Employment Monitoring Reports for the Website.	Equality Act	Interim Human Resources Director	Every two years – June 2021	**Ongoing** The Equalities Outcomes Update Report 2017-21 and 2021-25 including Workforce Monitoring and Non-Executive Board Member Gender Profile was developed in March / April 2021 for publishing in June 2021.
08	Commence Web Archiving with National Records Scotland (NRS).	Records Management Plan	Health Records	Ongoing	**Complete** Pages are available via the National Records for Scotland (NRS) website.
09	Undertake an annual review and update of the content on the ONELAN screens.	Comms	Head of Comms	By August each year	**Continues to be met**
10	Undertake annual reviews and updates of the State Hospital's Speakers' Directory and general presentation slides.	Comms	Head of Comms	By end April annually	**Complete** This update includes feedback from presentations.
11	Ensure Contingency Planning Comms contacts (Police, Fire and Ambulance) are updated.	Security Director	Head of Comms	Annually	**Continues to be met**
12	Bi-annual review of Media Training requirements for Directors and other identified staff.	Comms	Chief Executive / Head of Comms	March 2022	**N/A** No requirement in 2020/21.
13	Familiarisation with **'**Dealing with the Media' Guidance for State Hospital Spokespeople	Head of Comms	On-Call Directors / CEO	Ongoing	**N/A** No requirement in 2020/21. Note - This should be read in conjunction with the State Hospital's approved 'Media Lines for On-Call Directors' which have been prepared to assist Directors in responding to media enquiries.

No	QA Objective	Source	Lead	Timescale	Status / New Timescale
			Strategy / Policy		
14	Carry out an interim review and update (if required) of Communications strategies, policies and procedures.	Comms	Head of Comms	Annually	**Continues to be met** In 2021/22, the Communications Strategy 2015/20 will be reviewed and updated for the period 2021/25. Update due in 2020/21 was paused due to the Covid-19 pandemic and associated uncertainty around future ways of working.
15	Undertake Equality Impact Assessments for Communications.	Equality Act	Head of Comms	As required	**N/A** Last update was Summer 2019 so no requirement for update in 2020/21.
16	Undertake Data Protection Impact Assessments for Communications.	GDPR	Head of Comms	From 2021/22	**New for 2021/22** No requirement in 2020/21.
17	Develop Asset Registers for Communications.	GDPR	Head of Comms	From 2021/22	**New for 2021/22** No requirement in 2020/21.

7. QUALITY IMPROVEMENT (QI) OBJECTIVES

The following table shows performance against QI objectives set for 2020/21:

No	QI Objective	Source	Lead	Timescale	Status / New Timescale
			Internal Communications		
01	Develop a Communications Campaign to support the Hospital's migration to Office 365.	O365 Project Team	O365 Project Team / Head of Comms	By end 2020	**Complete** Head of Comms member of O365 Project Team. Staff Information Pack and O365 Suitcase developed along with training and other materials.
02	Develop a Communications Campaign to support the implementation of Microsoft Teams.	O365 Project Team	O365 Project Team / Head of Comms	By end 2020	**Complete** This was phase 2 of the above project.

No	QI Objective	Source	Lead	Timescale	Status / New Timescale
		Internal Communications			
03	Continue to undertake Staff Engagement Exercises to support corporate objectives.	CEO	Head of Corporate Planning & Business Support (HCPBS)	Ongoing	**Continues to be met** During the year this related to two Covid-19 surveys associated with the work of the Recovery and Innovation Group / Staff Wellbeing.
04	Develop a Communications and Engagement Plan to support change relating to the clinical care delivery model.	Clinical Model Oversight Board	PCIL / Head of Comms / Head of Corporate Planning & Business Support (HCPBS)	Ongoing	**Continues to be met**
05	Ensure effective communication with relevant stakeholders to share updates relating to strategic priorities including, Sickness Absence, and Nursing Resource Utilisation.	Chief Executive / Service Strategy / Directors' Objectives	All Directors	March 2021	**Continues to be met** This was dominated by the Covid-19 pandemic in 2020/21.
06	Promote the work of Healthy Working Lives (HWL)	Values & Behaviours Group (Sub Group of the Partnership Forum)	OD Manager / Head of Comms	Ongoing	**Continues to be met** Achieved through the staff bulletin and the production of resources.
07	Promote the launch of the Staff Wellbeing Centre and resources within.	Silver Command	Staff Wellbeing Centre staff / Head of Comms	Ongoing	**New for 2020/21** This was highly promoted in year.
08	Support / promote iMatter.	Board	OD Manager / OD & Learning Advisor / Head of Comms	Ongoing	**No requirement in year due to the Covid-19 pandemic** A national staff wellbeing survey took place instead.
09	Support the Staff and Volunteer 'Excellence Awards' and staff 'Long Service Awards' through a communications campaign.	Values & Behaviours Group	OD Manager / OD & Learning Advisor / Head of Comms	Annually	**No requirement in year due to the Covid-19 pandemic** Support takes the form of promotion before and after the event as well as the production of posters and certificates.

No	QI Objective	Source	Lead	Timescale	Status / New Timescale
			Internal Communications		
10	Enable patients to contribute to the voting process of the Staff and Volunteer 'Excellence Awards' through the use of tailored communications materials.	Excellence Steering Group	PCIL	Annually	**As above - No requirement in year due to the Covid-19 pandemic**
			External Communications		
11	Explore proactive measures with external Consultant to raise the Hospital's profile and address negative attitudes.	CEO / Board	Chief Executive / External Consultant / Head of Comms	June 2021	**New for 2020/21** **Phase 1 Complete** Materials were developed in 2020/21 for launch in June 2021. These included media features, videos and a voice recording.
12	Explore proactive approaches with external Consultant to raise the Hospital's profile and address negative attitudes.	CEO / Board	Chief Executive / External Consultant / Head of Comms	December 2021	**New for 2021/22** Phase 2 underway with the further development of materials.
13	Create a State Hospital presence on Social Media channels.	CEO / Board	Chief Executive / External Consultant / Head of Comms	June 2021	**New for 2020/21** **Complete** State Hospital Twitter, Facebook and YouTube channels were developed in 2020/21 for launch in June 2021.
14	Produce suitable content for the Hospital's Social Media Channels to maintain an effective presence.	CEO / Board	Chief Executive / External Consultant / Head of Comms	Ongoing from June 2021	**New for 2021/22** Will be met for Twitter, Facebook and YouTube.
15	Explore with Directors and senior staff the requirement to develop a visible presence on Social Media.	Head of Comms	Head of Comms	By March 2022	**New for 2021/22** To be considered in line with outcome of Barron Report. This will involve training as some staff will need coaching and technological support to be visible in the virtual world.

No	QI Objective	Source	Lead	Timescale	Status / New Timescale
			External Communications		
16	Redesign and relaunch of State Hospital Website.	Board	Head of Comms	Ongoing	**In progress** Work is taking place with NHS 24 to redesign the external website. First meeting took place in March 2020 but then paused due to Covid-19. Work will recommence at the end of 2021 when capacity allows.
17	Ensure research is shared through the Website.	Board	Research & Dev Mgr / Medical Director	March 2022	**On target**
18	Develop a suite of promotional materials for Recruitment.	Director of Nursing & AHPs	Head of Comms and Nursing Practice Development	March 2021	**New for 2020/21** **Complete**
			Collaborative Working		
19	Facilitate' What Matters To You?' initiative seeking the views of patients, carers and volunteers.	HIS	PCIL	Annual	**Continues to be met** Every June.
20	Be actively involved in the National Board Review Groups and work supporting the National Collaborative.	National Boards Collaborative	Head of Comms for Comms strand	As required	**Continues to be met** The State Hospital hosts a web page for use by the National Collaborative. Due to the Covid-19 pandemic this work was paused in 2020/21.
21	Review Memorandum of Understanding with another National Board as a means of strengthening resilience during any long-term absence.	National Boards Collaborative	Head of Comms / Chief Executive	By March 2022	**New for 2021/22**
22	With NHS Scotland Comms colleagues to provide communications around EU Exit Preparedness.	Strategic Comms Group	Head of Comms	As required	**Ongoing** In parallel with local resilience planning.

No	QI Objective	Source	Lead	Timescale	Status / New Timescale
			Collaborative Working		
23	Develop the leadership needs of NHS Scotland Communications professionals: Directors of Communications and Heads of Service.	Strategic Comms Group	Strategic Comms Leadership Sub Group	Ongoing	**N/A** Sub Group comprises the State Hospital, NHS Greater & Clyde, and NHS Golden Jubilee. This work was paused in 2020/21 in light of the Covid-19 pandemic.
			Equality, Diversity and Rights		
24	Undertake a scoping exercise relating to carer involvement in Care Programme Approach (CPA) review meetings / transfer planning process.	CSG / Carers Trust Scotland	PCIL	April 2020	**Complete** The scoping exercise highlighted the need for a more targeted approach to eliciting feedback relevant to specific stages of the carer journey.
25	Consult, publish and implement updated 2017/20 Equality Outcomes. Plus, consult and publish Equality Outcomes 2021/24.	PCISG	PCIL	April 2021	**Complete for both**
			Strategy / Policy		
26	Review Communications Resilience Risk Assessment (departmental risk register).	Risk Management	Head of Comms	As required	**Continues to be met**
27	Establish a media monitoring service.	Chief Executive	Head of Comms	March 2021	**In progress – paused in 2020/21 due to Covid-19** In December 2020 the Board approved National Services Scotland (NSS) to provide a free media monitoring service to the State Hospital. Work was paused before any reports were received but will recommence in 2021/22.
28	Develop a subset Media & Social Media Strategy for the Intellectual Disability Service and ensure actions captured within overarching Communications action plan.	Chief Executive	Head of Comms	November 2020	**Part Complete – due to Covid-19** Strategy was developed in November 2020 before work paused. Action plan will be developed in 2021/22.

8. OUTPUT / ACTIVITY

Throughout 2020/21 the focus was primarily on Covid-19 communications and engagement.

8.1 Stakeholder Communications

The year began with continued timely and regular Covid-19 communications to keep staff well informed of the pandemic position both locally and nationally. In times of incident command for Covid-19, a daily Covid-19 bulletin was produced following Silver Command meetings, with Gold Command communications being included following Gold Command meetings. A distinguishable new bulletin header was created to support the daily Covid-19 bulletin which included sections for patient care, staffing, infection control, and national / regional updates including campaigns and messaging.

Information, as it became available, was captured within the weekly staff bulletin (there being a specific Covid-19 section) and through dedicated bulletins for more detailed information, e.g. results of stakeholder engagement exercises, face mask guidance and lateral flow testing.

These bulletins were quickly adapted for patients and carers by the Person Centred Improvement Lead (PCIL) so all stakeholders were receiving the latest information promptly and simultaneously. A specific patient update was published in April 2020 covering 'Coronavirus: Keeping Everyone Safe and Well' in addition to the regular updates throughout the year. Each patient received the information in a format that was most suitable to them.

Staff, Volunteers, Non-Executive Directors and the Hospital's Auditors received a copy of weekly and dedicated staff bulletins including those for Covid-19. Silver Command daily Covid-19 bulletins were also shared with Scottish Government colleagues.

All user emails were issued to relay Covid-19 information that was urgent and could not wait until the next bulletin.

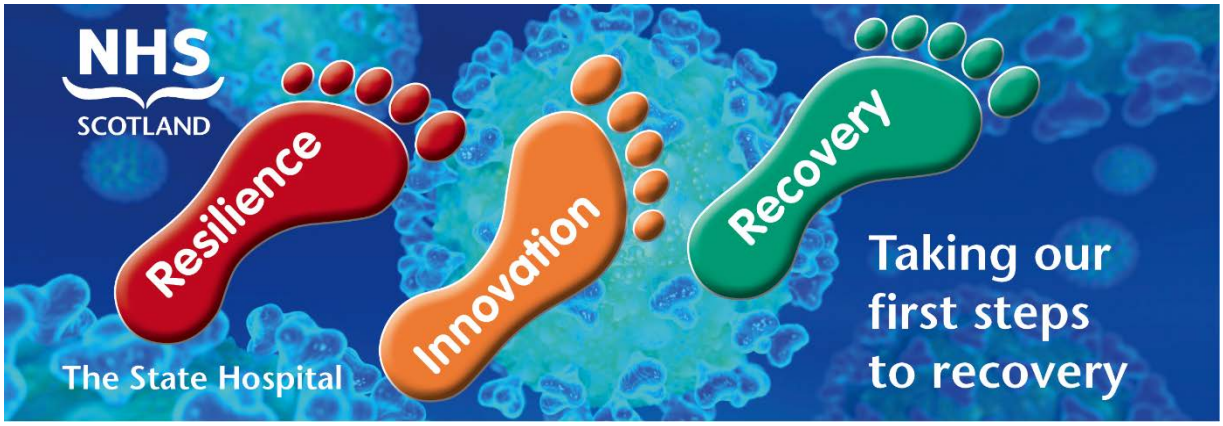
The dedicated Covid-19 Intranet page provided a one-stop shop for all Covid-19 information deemed relevant for staff including information on wellbeing resources and the development of a Covid-19 Staff Q&A document (May 2020) which continued to be updated throughout the year alongside the Intranet page. The Staff Wellbeing Zone in the Staff Development and Conference Centred (created for rest and relaxation, resources, quiet area) was promoted both through the bulletin and Intranet. All bulletins were housed on the Intranet for easy access 24 hours a day.

Covid-19 information on the Website was monitored and reviewed regularly with updates being made as required, e.g. visiting information for patient visitors and official visitors.

To ensure the Board had the opportunity to learn from the experience of patients, carers and volunteers, narratives regularly featured on the Board's agenda throughout the year. These were welcomed and very well received especially as the process of Non-Executive Board Members attending Patient Partnership Group meetings (on a rotational basis to hear directly from patients about their experience of care and treatment) was paused in 2020/21 due to Covid-19.

Media enquiries related to Covid-19 were shared with the Board and Scottish Government colleagues. Processes were in place for responding to Covid-19 FOI enquiries which were managed separately.

A number of Covid-19 promotional materials were produced including banner stands for the new Staff Wellbeing Centre in Harris (replacing the Staff Wellbeing Zone in Islay), and a new visually distinguishable banner was developed for Covid-19 bulletins going forward which was more reflective of the recovery journey.



8.2 Stakeholder Engagement

At no time had there been a greater need to meaningfully seek, listen to and act on feedback than during the Covid-19 pandemic. This involved effectively engaging with staff, patients, carers and volunteers to help develop services as part of the recovery journey. There were a number of key areas of activity:

- A survey which ran for six weeks.
- Staff teleconference discussions led by the Chief Executive involving multiple teams and individuals from across the organisation over a three-week period. Staff involved in these sessions received direct feedback in relation to the session they attended. Note - The twin approach enabled meaningful feedback from a third of the entire workforce.
- Patient walkrounds with the Chief Executive.

Associated feedback was shared in June 2020 in a format most suitable to each stakeholder group. For example, for staff, this was by way of a dedicated bulletin covering activity undertaken, key themes arising from the feedback / brief narrative of responses, and the next steps.

From the feedback received, 12 key topics were identified which were then embedded within the following six themes:

- Building a Personalised Approach to Care.
- Leadership and Culture.
- Digital Transformation.
- Physical Health of Patients.
- Staff Health and Wellbeing.
- Become Improvers and Innovators to support Clinical and Organisational Effectiveness.

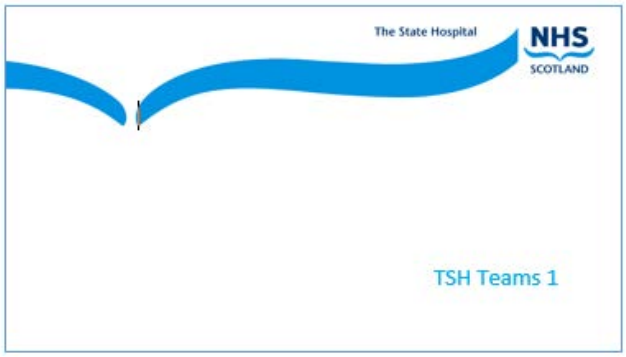
A Recovery and Innovation Group, chaired by the Chief Executive was established to ensure staff, patients and visitors continued to be well informed and engaged whilst remaining safe and healthy within the State Hospital environment. The Head of Communications and PCIL were key members of the group. The group used the stakeholder feedback to develop actions and workstreams to guide the recovery process.

Additional expressions of patient feedback were captured by way of the new Iona 2 Patient Partnership Group, the Covid-19 Graffiti Wall and Covid-19 poem.

8.3 Embedding Advancements in Communications Technology

In addition to being part of the Covid-19 Support Team in 2020/21, the Head of Communications was a member of the Microsoft Office 365 Project Team tasked with the Hospital's successful migration to Office 365 and subsequent implementation of Microsoft Teams and remote working – implementation of the latter two being accelerated as a result of the Covid-19 pandemic. This was a huge undertaking for most of the year with effective communication being critical to keep staff well informed and supported pre and post migration.

Migration was successful and the project was delivered on time. Teams background images were developed in support of NHS Scotland Corporate Identity and could be easily accessed / used by both staff on site and those working from home. Backgrounds comprised a mixture of Hospital campus photos and eight graphics, some of which are shown below:



8.4 Stakeholder Information Resources

Despite the main focus being on Covid-19 throughout the year, the Communications function supported the following disciplines, groups and departments with the review, update or development of new stakeholder information materials:

- AHPs.
- Communications.
- Health Records.
- Human Resources.
- Infection Control.
- Medical Directorate.
- Occupational Health.
- Physical Health Steering Group.
- Risk Management.
- Skye Centre Therapies & Activities.
- Social Work.

9. EVALUATION OF EFFECTIVENESS

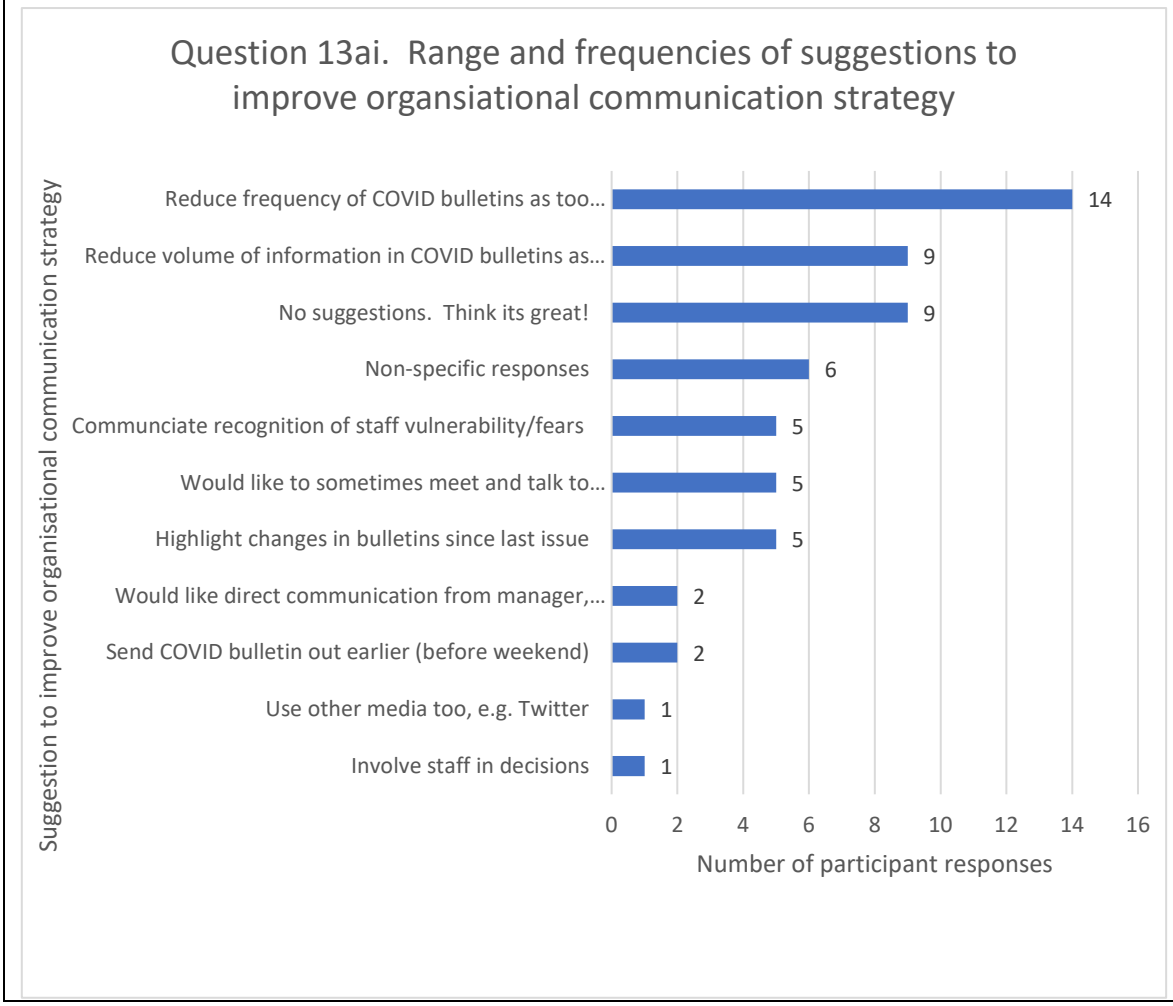
As Covid-19 communications were the main focus of 2020/21, evaluation is provided on this workstream.

An evaluation of the impact of measures adopted to promote positive staff health and wellbeing during the Covid-19 pandemic was undertaken and reported on in March 2021. The report highlighted effective and frequent communication as an important and helpful measure, and the importance of good communication as an essential element in the continued response to Covid-19.

The results from the additional qualitative questions around communications gave further information about suggestions staff made about possible improvements that could be made to each of the health and wellbeing measures provided.

Question 13ai: Can you suggest anything that can be done to improve your health and wellbeing related to the organisational communication strategy?

Results: 50/227 (22%) of participants gave further information about this, with a total of 59 overall comments made across 11 different themes categorised as 'suggestions to improve organisational communication strategy'.



10. CONCLUSION

2020/21 was an unprecedented year in which the need for a united voice to communicate national and local priorities and messaging clearly to all stakeholders (and in some cases, effect behavioural change and new ways of working) was vital.

The State Hospital's Communications function and PCIS were integral all year, playing a key role in amplifying or localising national public health messaging, as well as supporting and reassuring stakeholders as they got to grips with very different ways of doing things within the Hospital or at home, e.g. remote working, video visiting.

It is a pleasure to report that fast, effective and timely Covid-19 communications were achieved for all stakeholders through the Head of Communications and PCIL's rapid and flexible response to the difficult, dynamic situation of the pandemic.

Additionally:

- All core communication tasks (that could be taken forward during the pandemic including key performance indicators, quality assurance objectives and quality improvement objectives) were either progressed or completed.
- All legislative requirements were met, and all financial targets / savings were achieved.
- The communications aspect of the migration to MS O365, implementation of MS Teams and remote working was also effective and successful.

This was an extremely busy year for the Head of Communications to keep effective and quality communication flowing. This in itself highlighted the vital role played by the Communications function in achieving organisational success, and need for a review of this critical function.

Consideration should be given as to how the Communications function is resourced going forward. The level of change ahead is unparalleled with advancements in technology, new and innovative ways of working, and changes associated with the Barron Report recommendations. Involving stakeholders, making sure that they are meaningfully engaged, is essential to the ongoing development of service delivery that supports a person centred approach where patients, carers and volunteers feel they are valued and listened to. Inevitably this calls for more regular and different communication messages and activities on numerous platforms (many new) and often delivered at pace. Page 3, section 4 of this report refers.

11. KEY AREAS OF FOCUS IN 2021/22

In 2021/22 focus will be on delivering as many of the following priorities that capacity allows:

11.1 Communications Strategy / Policy / Annual Report

- Update of the Corporate Communications Strategy.
- Review of Communications Policies, Procedures, Protocols and Guidance.
- Review of Communications Local Risk Register.
- Review and delivery of Communications KPIs, QA Objectives and QI Objectives.
- Production of Communications Annual Report.
- Review and update of Pandemic Influenza Communications Strategy.

11.2 Investing for the Future (Building Capacity / Ensuring the Right Skill Mix)

- Investment in Communications Resource (ensuring specialist skills in new digital and PR techniques as well as shaping policy and managing communications channels more strategically and efficiently).
- Production of Communication Guides (if capacity allows).
- Build even better communications practice through lessons learned from the pandemic and adapting to new technologies and audience behaviours.

11.3 Media Relations / Public Relations / Public Affairs

- Development and delivery of Intellectual Disability Social Media Strategy.
- Establish a media monitoring system.
- Support work being undertaken by McLaws Consultancy.
- Develop a State Hospital Social Media presence on Twitter, Facebook and YouTube.
- Explore the requirement for Directors to be visible in the virtual world of social media / create and maintain an effective visible presence.
- Production of the State Hospitals Board for Scotland Annual Report.
- Complete Website Redevelopment and Launch.
- Keep the Scottish Government up-to-date with all media activity.

11.4 Marketing Communications

- Explore Video Production (capacity dependent).
- Explore Information Graphics / Digital Opportunities (capacity dependent).
- Ensure proper use of NHS Scotland Corporate Identity.

11.5 Service Redesign / Transformation / Recovery

- (National) Barron Report and EU Exit.
- (Local) Remobilisation and Clinical Model.
- Continue to help drive the pace and scale of the recovery journey by articulating how the Hospital intends to progress recovery from the Covid-19 pandemic and come back stronger.

11.6 Hospital Wide Publications

- Review of Hospital-wide Publications.
- Update of Publications Database.

11.7 Internal Communications

- Continue to meet the 'Well Informed' strand of the Staff Governance Standard.
- Promote the Board's vision and key priorities as the issues that were important before the pandemic and lockdown still matter.
- Create a more interactive website which offers a different way for carers and volunteers to share their views.
- Support the local Digital Inclusion workstreams which aim to enable patients to communicate using electronic forms of communication.

11.8 Other

- Continued provision of Expert Advice.
- Continued National Representation / Networking Opportunities.

Caroline McCarron Chart.PR MICPR
Head of Communications
October 2021

Paper No. 21/106

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	23 December 2021
Agenda Reference:	Item No: 24
Sponsoring Director:	Chief Executive
Author(s):	Board Secretary
Title of Report:	Corporate Governance Improvement Action Plan
Purpose of Report:	For Noting

1 SITUATION

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

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

2 BACKGROUND

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

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

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

Progress updates can be made in relation to the following:

Item 2	Effective rostering within the nursing directorate
Item 7	Review of the performance metrics framework
Item 10	Communications Strategy
Item 21	Non- Executive Director visibility and connection

3 ASSESSMENT

Item 2 – Effective rostering within the nursing directorate:

The Director of Nursing, AHPs and Operations provided a detailed update to the Board at its seminar session which took place on 23 September 2021. Work with National Workforce Team is continuing, aligned to the legislative positon for safe staffing, and a pause on reporting requirements nationally.

Reporting in this area is being routed through the Staff Governance Committee focussed on staffing issues and implementation of the legislative component; and the Clinical Governance Committee in respect of any potential impacts to the delivery of safe and effective care. Reporting is also routinely routed through the Organisational Management Team and Partnership Forum.

A 'safe to start' real time staffing assessment has been developed enabling reporting of nurse staffing levels daily on a risk rated basis.

A rostering masterclass was delivered to the Senior Charge Nurse cohort during 2021, with support from national safe staffing team. TSH has agreed to test a nationally agreed safe staffing readiness self-assessment template, which will be available in December 2021.

Work has been progressing in partnership with a view to agreeing a rostering protocol. A test of change has also been agreed as part of a review of the 5/7 shift pattern that was introduced in 2020. At its meeting on 15 December, the Corporate Management Team considered developments in relation to bank and supplementary staffing options. This was agreed in principle, and implementation planning will now be taken forward.

Item 7 – Review of the performance metrics framework:

The Board has received newly formatted reporting in 2021, to give greater clarity on performance in reporting of Key Performance Indicators (KPIs) as well as to highlight the key areas for improvement. PuMP methodology has been established within the hospital to support alignment of performance reporting and improvement priorities.

The Strategic Planning and Performance Group has responsibility in this area, reporting to the Corporate Management Team. A development session will take place on 13 January 2022 led by the Board Development team at NHS Education for Scotland.

Item 10 Communications Strategy

The Board has been focused on promoting the excellence of care provided within TSH, and helping to support greater public understanding of forensic mental health care. A progress update

on this strategy and programme will be presented to the Board in December 2021, to allow further consideration and discussion on the way forward.

Item 20 - Non-Executive Director visibility and connection

This action was necessarily paused during the pandemic to ensure alignment to the national position in terms of public health and infection control. The Non-Executive Directors appointed in 2021 have been able to access security induction as well as training in the Prevention and Management of Violence and Aggression enabling them to come on site.

A hybrid model of engagement has been taken forward enabling connectivity for Non-Executive Directors, including the possibility of on-site visits. However, the changing national position in terms of additional risk presented by the Omicron variant will impact this in the short term.

Due to the size of the event, the Staff Awards took place on 30 November 2021 on a digital platform, and included input from the Board Chair and Employee Director.

Leadership Walkrounds are scheduled to begin in January 2022, with confirmation that Non-Executive Directors will be able to participate. The Project Manager for this workstream is linking with Non-Executives to take this forward.

A schedule has also been set up to enable Non-Executive Directors to attend the Patient Partnership Group (PPG) in person. This will ensure a presence at one meeting a month, as well as the opportunity to link with the Person Centred Improvement Team to learn about the key issues the PPG is focused on.

These activities will be subject to consideration of risk due to the ongoing pandemic, and will be kept under close review.

4 RECOMMENDATION

The Board is asked to:

- Note the key areas of development, as well as the context in which some actions continue to be paused due to Covid-19.

Author:
Margaret Smith
Board Secretary
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Paper No. 21/106

MONITORING FORM

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

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

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

						and reduce overtime. This workstream will continue to be progressed in Partnership during 2021. Full update to Board Seminar in May 2021 (deferred). **Update August 2021:** Dedicated reporting to Staff Governance Committee on implementation of legislation, dedicated reporting to Clinical Governance Committee in respect of staffing inked to impact on care. Meeting with the National Workforce Team in September 2021, and presentation to Board as part of seminar in September. **Update December 2021:** Safe Staffing legislation/reporting paused. Reporting on staffing impacts in nursing embedded into fora (Clinical Governance Committee/ OMT/ Partnership Forum. Rostering masterclass delivered to SCNs with support from national safe staffing team. Agreed to test a nationally agreed safe staffing readiness self-assessment template, which will be available to us in December 2021 Implementation of a 'safe to start' real time staffing assessment and are reporting our nurse staffing levels daily on a risk rated basis Working in partnership to agree a rostering protocol and test of change on 5/7 shift pattern. CMT agreed bank and supplementary staffing options for future implementation, following work progressed in partnership.

	3	Development of more robust processes to compare planned and actual spend and to account for any variance.	Director of Finance and eHealth	CMT /Board	September 2019	**Completed:** Process in place- Planned and actual £ spend per budget line reviewed with each individual budget holder on a line-by-line basis from the 2019/20 mid-year 6-month reviews (30/9/19) – a summary of any significant or material variances is collated to be reported as appropriate.
HOLDING TO ACCOUNT	4	Ensure compliance with new national guidelines in management of Executive pay and performance through remuneration Committee approval for annual ESM pay and performance cycle.	Chair /Interim HR Director	Remuneration Committee	Ongoing	**Completed**
	5	Ensure implementation of attendance management policy through support from HR to line managers help identify and act upon patterns of absence. Continued implementation of the action plan developed through the Attendance Management Improvement Task Group (AMITG).	Interim HR Director	CMT	Ongoing 2019/20 – revised and completed	**Completed:** Once for Scotland Workforce Policy Implemented. Training for Line Managers and HR Managers delivered. Update presented on attendance management to each Board Meeting. Improvement activity now directed by the HR and Wellbeing Group.
	6	Implementation and compliance with Once for	Interim HR Director	Partnership Forum/CMT	New:	**Completed:**

		Scotland HR policies within TSH. Focus on policy awareness through completion of metacompliance / staff bulletins/ staff training in Single Investigatory process.			April 2022 national target	TSH readiness for planned implementation of phase 2 for April 2022. HR and Wellbeing Group is now well established and will support links with Partnership Forum/ Staff Governance Committee to ensure appropriate governance, with updates to the Board if required.
	7	Review performance framework and assurance information systems to support review of performance.	Head of Corporate Planning	CMT	New: **January 2022**	**On Track -** Strategic Review of Performance underway with draft performance framework in development based on balanced scorecard approach of better health better care, better value and better workforce. Operational definitions for suggested KPI's being developed with associated data sources identified. **Update: December 2020** Presentation to Board in November 2020, work progressing with oversight through CMT **Update April 2021**: Format of KPI report changed to provide clarity on KPI's performance and describe the areas for improvement. Data map developed to illustrate where data is reported across governance and management groups. PuMP pilot being taken forward with HR to support alignment of performance improvement and reporting of KPI's in line with Organisational priorities and linked to departmental priorities. **Update August 2021. P**uMP rolled out to EHealth following the HR programme, and

						underway. Performance Workbook created across directorates and linked to governance. Strategic Planning and Performance Group set up and met for first time in August 2021, reporting line to the CMT. Link also made to Active Governance workstream for board development session planned for November 2021. Further update to Board in due course. **Update December 2021:** Board Development Session on Active Governance scheduled for 13 January 2022, and Board will consider this action further following that. NES programme awaited for this.
	8	Blueprint Improvement Plan to be placed on Board Workplan for review at each Board Meeting.	Chair	Board	June 2019	**Completed**
ASSESSING RISK	9	Further development of risk management with focus on risk register to ensure this is clearly defined with set of mitigating measures against each risk which also have a focus on improvement actions.	Director Security, Resilience and Estates	Audit Committee / Board	New: June 2021	**Completed:** Work progressed to review the Corporate Risk register and link to development of local registers throughout TSH. Regular reporting of Corporate Risk Register to Board and tracked through monthly reporting at CMT and quarterly at OMT. Local Risk tracked and link made to CRR.

ENGAGING STAKEHOLDERS	10	Review and develop the Communications Strategy to include proactive engagement with aim of addressing dissonance between strategic aims of the hospital and public perception of these aims.	CEO	Board	New: **Roll out over June to December 2021**	**December 2019 -** Review of media strategy in progress with regular updates to the Board. **Update: December 2020** Presentation to Board seminar November 2020, and re-engagement of workstream at start of 2021. **Update April 2021-** Work being progressed January to June 2021 in preparation for roll out. **Update December 2021:** Presentation by Head of Communications to Board.
	11	Promotion of The State Hospital as an employer in the local area. Increase number of modern apprenticeships. Participate in local school careers events, local and university recruitment fairs.	Interim HR Director	CMT	New: August 2021	**Completed** Full range of recruitment activity in place.
	12	Encourage carers / volunteers /staff / local population to attend public Board Meetings through additional promotion and links with local community.	Board Secretary	Board	**New: Review April 2022**	**On Track** – through promotion of external Board Meetings /Annual Review session in 2020. **Update: December 2020** Reviewed in Board Seminar November 2020, and awaiting national guidance. Local review to be taken forward to engage virtually. **Update: February 2021**: Board agreed value of digital means of engagement and further work to be take forward to enable this to be taken

						forward linking to attendance by patients as well. **Update August 2021:** Board to consider further in September Development Session **Update December 2021:** Board received presentation in development session to review the options and consider within context of continuing impacts of Covid-19. Decision to necessarily pause until Spring 2022. In meantime encouragement given through CMT to staff to attend as observers in digital meetings when possible.
	13	Hold two Board Meeting each year at external locations to promote role as national Board.	Board Secretary	Board	Paused due to Covid-19 restrictions	**Update: February 2020:** Board Meeting 27 February in Lanark Memorial Hall, digital participation under review. **Update August 2021:** Board to consider further in September Development Session **Update December 2021:** detailed consideration by Board in context of Covid-19 in development session. ON HOLD
	14	Annual Review - Public Meeting to be held outside of the hospital to help engage public engagement and attendance.	Board Secretary	Board	Paused due to Covid-19	**Update: December 2019:** Plan to be progressed as part of Annual Review. The review in 2020 was redesigned due to Covid-19. Awaiting national guidance for the current year. **Update December 2021:** Confirmation of virtual Annual Review for 2020/21, likely in March 2022. ON HOLD
INFLUENCING CULTURE	15	Define culture in The State Hospital in terms of key strengths and	CEO	Board	New: August 2021	**Completed:**

		weaknesses - take forward through development sessions				**Update: February 2020** Progressed in conjunction with response to Sturrock and Clinical Model Review – Culture, Values & Behaviours, Leadership workstream led by CEO. **Update: December 2020** Workstream re-formulated and developed more widely under Recovery and Innovation Group during Covid. Planning in place for development of this framework in spring 2021, and reporting to come to Board as part of workplan. **Update: April 2021** A programme of work, from the themes identified through the staff engagement activity has been taken forward. Oversight of the Recovery and innovation group is through CMT, and updates to all staff through bulletin. Future developments will connect through the staff HR and Wellbeing group **Update:August2021:** Workstream led through HR and Wellbeing. Staff wellbeing reporting comes to Board as part of covid reporting, with dedicated reporting to replace this at end of pandemic as part of overall workforce reporting/ workplan.
	16	Implement a Staff Recognition Scheme for long service as well as individual contribution to the organisation.	Interim HR Director	CMT	September 2019	**Completed**- first ceremony 24 October 2019.

	17	Embed a culture of quality across the organisation through initiatives such as TSH3030, Quality Forum and sharing our work more widely.	CEO	CMT	February 2020	**Completed and Board now gets full updates at each meeting.**
	18	Senior Management visibility through regular front line staff engagement meetings with CEO / Directors' Group - plan a calendar of events to ensure regular engagement.	CEO	CMT	New: **Review April 2022**	**Update: December 2019** wider engagement across TSH – progressed in conjunction with response to Sturrock and Clinical Model Review. **Update: December 2020** This agenda has been developed throughout the incident command structure period, with strengthening of layers of leadership. Key learning has been taken and progressed through to interim management structure. **Update: April 2021** Review of digital means of connection under development with software procured. Training and development to be progressed for rollout **Update December 2021:** Directors schedule on site is produced weekly ensuring on site presence rather than digital links. Directors lead on engagement with teams to ensure visibility. Hospital events not being taken forward face to face so remainder of action ON HOLD.
	19	Senior Team / RMO presence at key events in hospital calendar e.g. patient learning awards/	CEO / Medical Director	CMT	New: **Review April 2022**	**Update: December 2019** Coordination of central diary of events to help facilitate attendance. **Paused due to Covid-19**

		sportsman dinner. Promote this through management structures.				**Update August 2021:** Covid restrictions depending event planning through hybrid of in person and digital means with coordination of diary to be led through Corporate Services Team and in place for October 2021. **Update December 2021:** Hospital events not being taken forward face to face. Digital platform for Staff Awards. Remainder of action ON HOLD.
	20	Link in with Scottish Government once appointment of the Independent National Whistleblowing Officer and Board Champion has been appointed.	Change to Interim HR Director	Board	March 2021	**Completed**
	21	Plan a schedule of Non-Executive Director informal visits across TSH to help promote the values and behaviours of the organisation.	Chair	Board	New: **Update to Board December 2021**	**February 2020** - Schedule in place for patient and staff engagement with NXD attendance at PPG meetings. **Paused due to Covid-19** **Update: December 2020** Restart may be possible in 2021. PPG meetings have, in part re-commenced virtually, explore possibility of NXD attendance at these meeting virtually. Digital agenda being progressed including online staff engagement for Exec Team. This should be progressed to include NXDs. **Update April 2021:** PPG meetings taking place in person for ID population, and new video conferencing

						equipment under procurement for wider patient group. Non- Executive attendance to be kept under review for 2021 when possible. **Update August 2021:** Covid restrictions depending, non –executive presence on site now being taken forward as per hybrid model of engagement. Workplan Including PPG/ Leadership Walkrounds planned for October 2021 onwards. Link to hospital events such as staff awards through digital means. **Update December 2021:** PPG link and meeting schedule /Patent Safety Walkrounds schedule established (depending on any future restrictions). Link to Staff awards available to Non Execs.

Updated 16.12.21

M Smith

Paper No. 21/107

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	23 December 2021
Agenda Reference:	Item No: 25
Sponsoring Director:	Chief Executive
Author(s):	Board Secretary
Title of Report:	Board Workplan
Purpose of Report:	For Decision

1 SITUATION

The Board requires to review its workplan for the coming year to identify the key considerations and actions required during 2021, and to provide assurance on planned areas of reporting.

2 BACKGROUND

The Board considers and approves a workplan annually, and the Board Secretary will support the Board by ensuring that each component part of the workplan is allocated to meeting(s) throughout the year.

3 ASSESSMENT

The workplan has been developed to encompass the key focus areas for the Board in the coming year, and is enclosed at Appendix A. It is acknowledged that due to the continuing impacts of Covid-19 some adjustment to this workplan may be required throughout this period of reporting. The extent of the impacts of Covid-19 cannot confidently be predicted at present, and the Board can expect some changes to the reporting plan may be required across its business. The workplan has been adjusted to reflect this and ensure that this is considered in all aspects of strategic planning and operational delivery.

There is a focus on key workstreams, with the Clinical Model implementation reporting to every second meeting and Supporting Healthy Choices twice within the year.

Service planning reports (Remobilisation Plan/ Future Operational Plan) have been added to the February, April and June meetings though the timings may require to be reviewed subject to national guidance. Workforce planning has been added to align with this with reporting expected to be within a similar timeframe. Safe Staffing reporting has been planned to commence in the last six months though this will be subject to national guidance.

Some changes have been made to the timings for regular annual reporting, to ensure that all annual reporting has been received by the Board no later than the October meeting. In particular, Risk and Resilience reporting will be brought forward to the June meeting, and will therefore also require to be routed to the June Audit Committee. Similarly, eHealth reporting is brought forward in the plan give the key importance of this area.

It should also be noted that the Board is required to submit annual reporting on climate change actions and sustainability by November each year, and so that has been added to the October meeting.

The Person–Centred Improvement Service Report will be remitted to the Clinical Governance Committee for detailed oversight, in line with annual reporting in other key clinical areas e.g. Rehabilitation, Skye Centre. The Board will continue to receive presentations from the team providing direct experience from patients and carers

4 RECOMMENDATION

The Board is asked to:

- Review the revised workplan and discuss whether this provides a robust structure for the consideration and scrutiny of the Board's business in 2022, advising whether any change or addition is required.

- Note the potential for changes to the plan, subject to Covid-19.

- Approve the plan as a basis for managing Board business in 2022.

Author:
Margaret Smith
Board Secretary
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Paper No. 21/107

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	To support the Board's Corporate Objectives and strengthen reporting to and oversight by the NHS Board
Workforce Implications	There are no implications as a result of this report
Financial Implications	There are no impacts to consider.
Route To Board Which groups were involved in contributing to the paper and recommendations.	Requested by the Board as part of workplan, and directed through the Corporate Management Team.
Risk Assessment (Outline any significant risks and associated mitigation)	The workplan is developed to provide assurance to the Board, and there are no additional risks to consider
Assessment of Impact on Stakeholder Experience	This is considered by the Board in setting its workplan
Equality Impact Assessment	Not required
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	Not relevant
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One X There are no privacy implications. □ There are privacy implications, but full DPIA not needed □ There are privacy implications , full DPIA included.

THE STATE HOSPITALS BOARD FOR SCOTLAND: BOARD BUSINESS 2022

24 February 2022	28 April 2022	23 June 2022	25 August 2022	27 October 2022	22 December 2022
• Board Minute and Actions • Chair's Report • CEO Report	• Board Minute and Actions • Chair's Report • CEO Report	• Board Minute and Actions • Chair's Report • CEO Report	• Board Minute and Actions • Chair's Report • CEO Report	• Board Minute and Actions • Chair's Report • CEO Report • Annual Schedule of Board/Committee meetings	• Board Minute and Actions • Chair's Report • CEO Report
• Governance Committee Minutes • Clinical Forum Minutes • Annual Review Feedback (2020/21)	• Governance Committee Minutes • Clinical Forum Minutes • Corporate Governance Update	• Governance Committee Minutes • Clinical Forum Minutes • Governance Committee Annual Reports • Clinical Forum Annual Report	• Governance Committee Minutes • Clinical Forum Minutes • Corporate Governance Update	• Governance Committee Minutes • Clinical Forum Minutes	• Governance Committee Minutes • Clinical Forum Minutes • Corporate Governance Update
• Covid Response and Recovery • Covid Finance Update	• Covid Response and Recovery • Covid Finance Update	• Covid Response and Recovery • Covid Finance Update	• Covid Response and Recovery • Covid Finance Update	• Covid Response and Recovery • Covid Finance Update	• Covid Response and Recovery • Covid Finance Update

24 February 2022	28 April 2022	23 June 2022	25 August 2022	27 October 2022	22 December 2022
• Clinical Model Implementation • Supporting Health Choices Programme • Quality Assurance and Improvement • Infection Control * • Patient Flow *	• Patient, Carer & Volunteer Stories • Nurse and AHP Revalidation Report • Quality Assurance and Improvement • Infection Control * • Patient Flow *	• Clinical Model Implementation • Quality Assurance and Improvement • Infection Control * • Patient Flow *	• Patient, Carer and Volunteer Stories • Supporting Healthy Choices Programme • Implementation of Specified Persons Annual Report • Quality Assurance and Improvement • Infection Control * • Patient Flow *	• Clinical Model Implementation • Medical Appraisal and Revalidation Annual Report • Medical Education Report • Quality Assurance and Improvement • Infection Control * • Patient Flow *	• Patient, Carer and Volunteer Stories • Patient Advocacy Annual Report • Quality Assurance and Improvement • Infection Control * • Patient Flow *
• Attendance Performance • iMatter Update • Whistleblowing Quarter 3 Report • Staff Wellbeing Report *	• Attendance Performance • Wellbeing Strategy • Whistleblowing Quarter 4 Report • Staff Wellbeing Report *	• Attendance Performance • Workforce Plan 2022/25 *(subject to national guidance)* • Staff Wellbeing Report *	• Attendance Performance • Safe Staffing Report *(tbc subject to Covid-19)* • Whistleblowing Quarter 1 Report • Staff Wellbeing Report *	• Attendance Performance • Safe Staffing Report *(tbc subject to Covid-19)* • Staff Wellbeing Report *	• Attendance Performance • Safe Staffing Report *(tbc subject to Covid-19)* • Whistleblowing Quarter 2 report and Annual Statement • Staff Wellbeing Report *

24 February 2022	28 April 2022	23 June 2022	25 August 2022	27 October 2022	22 December 2022
• Finance Report • Corporate Objectives 2022/23 • Performance Report Quarter 3 • Security Project • Remobilisation Plan Update • Corporate Risk Register	• Finance Report • Annual Review of Standing Documentation • Security Project • Digital Strategy Update • Remobilisation Pan Update • Corporate Risk Register	• Finance Report • Annual Accounts • Performance Annual Report • PAMS Submission • Security Project • Risk and Resilience Annual Report • Future Operational Plan 2022/25 *(subject to national guidance)* • Corporate Risk Register	• Finance Report • Performance Report Quarter 1 • Complaints Annual Report • Corporate Risk Register	• Finance Report • Communications Annual Report • Information Governance Annual Report • eHealth Annual Report • Digital Strategy Update • Sustainability Report	• Finance Report • Performance Report Quarter 2 • Corporate Risk Register

** Currently reported through Covid-19 resilience reporting.*

Paper No. 21/108

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	23 December 2021
Agenda Reference:	Item No: 26
Sponsoring Director:	Director of Security, Resilience and Estates
Author(s):	Risk Management Facilitator
Title of Report:	Corporate Risk Register Update
Purpose of Report:	For Decision

1 SITUATION

A corporate risk is a potential or actual event that:

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

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

This report serves as a draft for the new format of report that will go to both CMT and The Board, the main focus is to have a narrative on the current High and Very High risks on the Corporate Risk Register.

2 BACKGROUND

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

3 ASSESSMENT

3.1 Current Corporate Risk Register - See appendix A.

3.2 Review Dates

Risk Assessment	Due Date	Responsible Director
CE11	01/11/21	Chief Executive
CE12	01/11/21	Chief Executive

3.3 Proposed Risks for inclusion on Corporate Risk Register

N/A

3.4 Corporate Risk Register 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 – has been increased from Major x Likely (High) to Major x Almost Certain increasing the overall rating to Very High following a review at CMT. Likelihood increased due to the potential risk to staffing numbers from Omicron variant. Situation being monitored through Incident Command.

Ref	Initial Grading	Current Grading	Target Grading	Owner	Next Review	Group Monitoring Risk	Review Frequency	Change
Corporate SD 53	Major x Almost Certain	Major x Almost Certain	Major x Rare	Chief Executive	01/01/22	CMT/Infection Control	Fortnightly	Likelihood ↑

SD53 - Serious security breaches (eg escape, intruder, serious contraband) – has been increased from Extreme x Rare (Medium) to Extreme x Unlikely increasing the overall grading of the risk to High. The likelihood of this risk being realised has increased due to ongoing works within the hospital grounds involving at height equipment which is the full height of the fence. The area of the work is also located opposite the wards and patients bedrooms allowing patients to monitor and observe the ongoing work and potentially plan and attempt to escape. Grounds Access is still active as part of patients care in TSH . Control measures are detailed in section 3.5, the risk will continue to monitored over the coming weeks and months and risk assessment will be adjusted to reflect any required changes. Full risk assessment available in Appendix B.

Ref	Initial Grading	Current Grading	Target Grading	Owner	Next Review	Group Monitoring Risk	Review Frequency	Change
Corporate SD 53	Extreme x Unlikely	Extreme x Unlikely	Extreme x Rare	Security Director	01/01/22	CMT/Risk and Resilience Committee	Monthly	Likelihood ↑

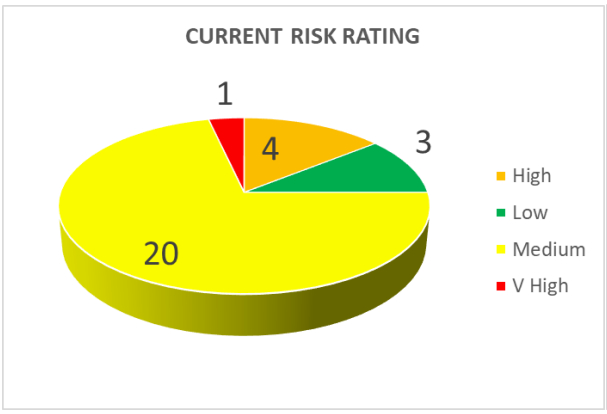
3.5 High and Very High Risk – Monthly Update

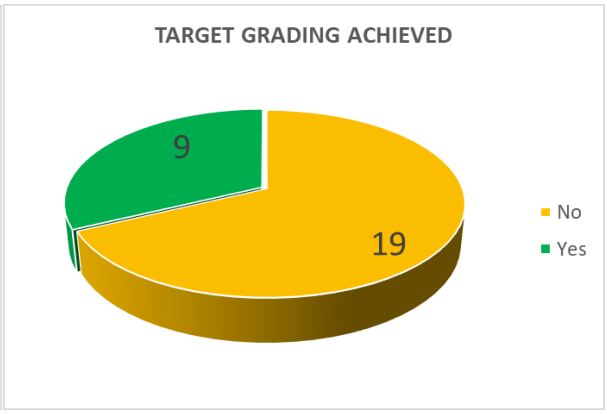
The State Hospital currently has 1 Very High risk and 4 High graded risks, latest updates are below:

Risk	Current Grading	Latest Update – December 2021
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	**Major X Almost Certain**	CMT agreed to keep to move risk to Very High (likelihood up from likely to almost certain) due to potential risk to staff numbers. Risk Assessment reviewed at CMT fortnightly and Infection Control Monthly. Latest updates include guidance from SG relating to delaying Christmas parties and gatherings and introduction of daily lateral flow testing.
ND70: Failure to utilise our resources to optimise excellent patient care and experience	**Moderate x Likely**	Staffing issues continue to affect TSH. Daily meeting takes place to monitor staff resources in real time. Recruitment ongoing.
ND71: Failure to assess and manage the risk of aggression and violence effectively	**Major X Possible**	**Risk is at target level:** Continues to be managed effectively with existing procedures and training. Violence and aggression incidents monitored by Risk & Resilience Team.

MD30**:** Failure to prevent/mitigate obesity	**Major X Likely**	Obesity figures look better than last month – but 2 obese patients (BMI over 40) refused measurements which swayed results. SHC project manager post and SHC remit going forward. Training update and plans for weight history screening following admission .
SD53: Serious security breaches (eg escape, intruder, serious contraband)	**Extreme X Unlikely**	<u>December 2021:Additional temporary hazards.</u> Current Security Upgrade work in place At Height Equipment working directly on fence line Full patient vision of work ongoing (possible opportunity to plan) Opportunity to ascend fence and escape Reduced staffing levels for response Equipment failure whilst at work December 2021 Update: • Patients fully risk assessed for grounds access. • All patients searched prior to entering grounds • Increase review of patients grounds access following behavioural incidents during this time. • Remove use of patio areas during fence line work weekdays only. • Move to centralised grounds access weekdays only • Control Room to closely monitor surrounding areas of work. • Escorting and contractor staff to be fully briefed regarding patients observing them at work. • Escorting staff reminded to be vigilant towards the risk of patients approaching. • Protocol for patient approach created. • At height equipment can be made immobile quickly by operator and lowered to a negligible height within 20 seconds. • If equipment failure takes place and immediate withdrawal of grounds access will be implemented by the control room. Escorted movement will only be allowed during this time following risk assessment by security. • Ensure Responder Model is maintained. With all the added controls in place the likelihood is significantly reduced. The only time the risk may be HIGH is if the equipment fails at height. This is covered by the protocols and controls above to mitigate such an event.

3.6 Risk Distribution





Risks not at target level	
CE14 – Coronavirus	**HRD110 Failure to implement and continue to develop the workforce plan**

MD30 – Failure to prevent/mitigate obesity	**HRD111 Deliberate leaks of information**
ND70 Failure to utilise our resources to optimise excellent patient care and experience	**HRD112 Compliance with mandatory PMVA Level 2 refresher training.**
SD53 - Serious security breaches (eg escape, intruder, serious contraband)	**MD32 Absconsion of patients**
SD51 - Physical or electronic security failure	**CE12 Failure to utilise appropriate systems to learn from prior events internally and externally**
SD52 - Resilience arrangements that are not fit for purpose	**FD91 – IT System Breach**
SD54 – Climate Resilience arrangements that are not fit for purpose	**FD90 Failure to implement a sustainable long term model**
SD55 - SD55 Negative impact of EU exit on the safe delivery of patient care within The State Hospital	**FD96 - Cyber Security/Data Protection Breach due to computer infection**
SD56 - Water Management	**ND73 Lack of SRK trained staff**
SD57 Failure to complete actions from Cat 1/2 reviews within appropriate timescale	

A workplan will be created to focus on risks not at target level in Q4 2021/22, this will be taken forward by the Risk & Resilience Team who will liaise with risk owners.

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

Review Periods:

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

4 RECOMMENDATION

The Board are invited to note and review the current Corporate Risk Register and to feedback any comments and/or additional information members would like to see in future reports to the group and the Board.

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
Risk Assessment (Outline any significant risks and associated mitigation)	There are no significant risks related to the publication of the report.
Assessment of Impact on Stakeholder Experience	There is no impact on stakeholder experience with the publication of this report.
Equality Impact Assessment	The EQIA is not applicable to the publication of this report.
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do)	The Fair Scotland Duty is not applicable to the publication of this report.
Data Protection Impact Assessment (DPIA) See IG 16	Tick One ✓ There are no privacy implications. ☐ There are privacy implications, but full DPIA not needed ☐ There are privacy implications, full DPIA included

Appendix A

Ref No.	Category	Risk	Initial Risk Grading	Current Risk Grading	Target Risk Grading	Owner	Action officer	Next Scheduled Review	Governance Committee	RA	AP	Monitoring Frequency	Movement Since Last Report
Corporate CE 10	Reputation	Severe breakdown in appropriate corporate governance	Extreme x Possible	Extreme x Rare	Extreme x Rare	Chief Executive	Board Secretary	01/03/22	Board	Y/Y	N/A	Quarterly	-
Corporate CE 11	Health & Safety	Risk of patient injury occurring which is categorised as either extreme injury or death	Extreme x Possible	Extreme x Rare	Extreme x Rare	Chief Executive	Chief Executive	31/10/21	Clinical Governance	Y/Y	N/A	Quarterly	-
Corporate CE 12	Strategic	Failure to utilise appropriate systems to learn from prior events internally and externally	Major x Possible	Moderate x Possible	Moderate x Unlikely	Chief Executive	Risk Management Team Leader	31/10/21	Risk and Resilience Group	Y/Y	N/A	Quarterly	-
Corporate CE 13	Strategic	Inadequate compliance with Chief Executive Letters and other statutory requirements	Moderate x Unlikely	Moderate x Rare	Moderate x Rare	Chief Executive	Board Secretary	01/06/21	CMT	Y/Y	N/A	6 monthly	-
Corporate CE 14	ALL	The risk that Coronavirus (Covid-19) could affect The State Hospitals primary aim to provide high quality, effective care and treatment and maintain a safe and secure environment for patients and staff.	Major x Almost Certain	Major x Almost Certain	Minor x Possible	Chief Executive	Chief Executive	27/12//21	CMT	Y/Y		Fortnightly	Likelihood ↑
Corporate MD 30	Medical	Failure to prevent/mitigate obesity	Major x Likely	Major x Likely	Moderate x Unlikely	Medical Director	Lead Dietitian	01/01/22	Clinical Governance Committee	Y/Y	Y/Y	Monthly	-
Corporate MD 32	Medical	Absconsion of Patients	Major x Unlikely	Major x Rare	Moderate x Rare	Medical Director	Associate Medical Director	01/03/22	CMT	Y/Y	N/A	Quarterly	-
Corporate MD 33	Medical	Potential adverse impact arising from clinical presentation out of hours with no doctor on site (5pm - 6pm)	Moderate x Unlikely	Moderate x Unlikely	Moderate x Unlikely	Medical Director	Associate Medical Director	01/03/22	CMT	Y/Y	N/A	Quarterly	-
Corporate MD 34	Medical	Lack of out of hours on site medical cover	Major x Unlikely	Major x Unlikely	Major x Unlikely	Medical Director	Associate Medical Director	01/03/22	CMT	Y/Y	N/A	Quarterly	-

Corporate SD 50	Service/Business Disruption	Serious Security Incident	Moderate x Possible	Moderate x Possible	Moderate x Possible	Security Director	Security Director	01/03/22	CMT	Y/Y	N/A	Quarterly	-
Corporate SD 51	Service/Business Disruption	Physical or electronic security failure	Extreme x Unlikely	Major x Unlikely	Major x Rare	Security Director	Security Director	01/03/22	Audit Committee	Y/Y	Y/Y	Quarterly	-
Corporate SD 52	Service/Business Disruption	Resilience arrangements that are not fit for purpose	Major x Unlikely	Moderate x Unlikely	Moderate x Rare	Security Director	Security Director	01/03/22	CMT	Y/Y	N/A	Quarterly	-
Corporate SD 53	Service/Business Disruption	Serious security breaches (eg escape, intruder, serious contraband)	Extreme x Unlikely	Extreme x Unlikely	Extreme x Rare	Security Director	Security Director	01/03/22	CMT/Risk and Resilience Committee	Y/Y	Y/Y	Quarterly	Likelihood ↑
Corporate SD 54	Service/Business Disruption	Climate change impact on the State Hospital	Minor x Possible	Moderate x Possible	Minor x Possible	Security Director	Head of Estates and Facilities	01/03/22	CMT/Risk and Resilience Committee	Y/Y	N/A	Quarterly	-
Corporate SD 55	Service/Business Disruption	Negative impact of EU exit on the State Hospital	Moderate x Unlikely	Moderate x Unlikely	Moderate x Rare	Chief Executive	Security Director	01/03/22	CMT	Y/Y	N/A	Quarterly	-
Corporate SD 56	Service/Business Disruption	Water Management	Major x Unlikely	Major x Unlikely	Major x Rare	Security Director	Head of Estates and Facilities	01/03/22	Infection Control Committee	Y/Y	N/A	Quarterly	-
Corporate SD57	Health & Safety	Failure to complete actions from Cat 1/2 reviews within appropriate timescale	Moderate x Possible	Moderate x Possible	Moderate x Unlikely	Finance & Performance Director	Head of Corporate Planning and Business Support	30/01/22	CMT	Y/Y	N/A	Quarterly	-
Corporate ND 70	Service/Business Disruption	Failure to utilise our resources to optimise excellent patient care and experience	Moderate x Possible	Moderate x Likely	Minor x Unlikely	Director of Nursing & AHP	Director of Nursing & AHP	01/01/22	CMT	Y/Y	Y/Y	Quarterly	-
Corporate ND 71	Health & Safety	Failure to assess and manage the risk of aggression and violence effectively	Major x Possible	Major x Possible	Major x Possible	Director of Nursing & AHP	Director of Nursing & AHP	01/01/22	CMT	Y/Y	Y/Y	Monthly	-
Corporate ND 73	Service/Business Disruption	Lack of SRK trained staff	Moderate x Likely	Moderate x Possible	Moderate x Unlikely	Director of Nursing & AHP	Director of Nursing & AHP	01/03/22	PMVA Group and CMT	Y/Y	N/A	Quarterly	-

Corporate FD 90	Financial	Failure to implement a sustainable long term model	Moderate x Unlikely	Moderate x Unlikely	Moderate x Rare	Finance & Performance Director	Finance & Performance Director	31/12/21	Audit Committee, RF&P Group & CMT	Y/Y	N/A	Quarterly	-
Corporate FD 91	Service/Business Disruption	IT system failure/breach	Moderate x Possible	Moderate x Possible	Minor x Possible	Finance & Performance Director	Head of eHealth	31/12/21	Information Governance Group & CMT	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	CMT/ Risk and Resilience Committee	Y/Y	N/A	Quarterly	-
Corporate FD 96	Service/Business Disruption	Cyber Security/Data Protection Breach due to computer infection	Moderate x Unlikely	Moderate x Unlikely	Moderate x Rare	Finance and Performance Director	Head of eHealth	01/01/22	CMT/Risk and Resilience Committee	Y/Y	N/A	6 Monthly	-
Corporate FD 97	Reputation	Unmanaged smart telephones' access to The State Hospital information and systems.	Major x Likely	Moderate x Rare	Moderate x Rare	Finance and Performance Director	Head of eHealth	31/12/21	Information Governance Group & CMT	Y/Y	Y/Y	Quarterly	-
Corporate HRD 110	Resource	Failure to implement and continue to develop the workforce plan	Moderate x Possible	Moderate x Unlikely	Minor x Rare	Interim HR Director	Interim HR Director	01/03/22	CMT	Y/Y	N/A	Quarterly	-
Corporate HRD 111	Reputation	Deliberate leaks of information	Major x Possible	Major x Unlikely	Moderate x Unlikely	Interim HR Director	Interim HR Director	01/03/22	CMT	Y/Y	Y/N	Quarterly	-
Corporate HRD 112	Health & Safety	Compliance with Mandatory PMVA Level 2 Training	Major x Unlikely	Moderate x Possible	Major x Rare	Interim HR Director	Training & Professional Development Manager	01/03/22	H&S Committee	Y/Y	N/A	Quarterly	-

Appendix B

Risk of Security Breaches Corporate SD 53

Category	Service / Business Interruption	**Risk Owner**	Security Director	**Action Officer**	Security Director

Risk	Complete the relevant details of the operation/ activity giving risk to the risk
Serious security breaches (eg escape, intruder, serious contraband) December 2021 Update Current risk is raised due to operational works taking place within internal grounds and perimeter as part of the Security Upgrade. As part of the upgrade contractors are required to work internally on the fence with at height equipment. The equipment is at full height of the fence as operators work on motion detection technology, creating the possibility of a climbing aid to a potential escape attempt. The boom of the equipment has no ladder or foot holds, but still has the potential to aid. The areas of work are directly opposite the wards and patients' bedrooms allowing the patients to fully observe the ongoing work. The risk is that a patient can plan, review times and have the potential to attempt to escape with the opportunity being presented by the ongoing works and the close proximity to the wards. To withdraw grounds access fully for this time would affect direct patient care, but consideration should be given to changing or reducing grounds access for the period of ongoing work to escorted or centralised.	

Type of Risk		Tick the box to indicate the type of risk
Staffing		
Financial & Organisational	X	
Clinical	X	
Physical	X	
Project		
Other (specify)		

Hazards		Details the hazards associated with this risk, i.e. the effect. Impact of this risk if realised
Uncontrolled patient at large Uncontrolled member of public within site Patient in possession of uncontrolled and dangerous articles or substances. <u>December 2021:Additional temporary hazards.</u> Current Security Upgrade work in place At Height Equipment working directly on fence line Full patient vision of work ongoing (possible opportunity to plan) Opportunity to ascend fence and escape Reduced staffing levels for response Equipment failure whilst at work		
Individuals or groups exposed	All Staff, Patients, Visitors and General Public	Highlight those who would be affected by risk

Benefits	Detail any benefits associated with this risk being realised. (e.g. cost savings

Existing Control Measures	List any existing measures in place to mitigate this risk.
1. Security checks on goods and people entering the hospital. 2. Searching policy and procedures. 3. Substance abuse testing. 4. Drug Detection Dogs. 5. Staff training. 6. Monitoring through Datix. 7. Annual security audit. 8. Perimeter security systems. 9. Reception security systems. 10. 24-hour control room 11. Daily perimeter checks 12. Internal CCTV. 13. Physical Security refresh project being undertaken – completion April 2022 14. Patient criminal intelligence 15. Visitors authorised via Social Work department prior to acceptance of visits	

Likelihood	Impact/ Consequence				
	Negligible	Minor	Moderate	Major	Extreme
Almost Certain	Medium	High	High	V High	V High
Likely	Medium	Medium	High	High	V High
Possible	Low	Medium	Medium	High	High
Unlikely	Low	Medium	Medium	Medium	High
Rare	Low	Low	Low	Medium	Medium

Risk Rating Refer to the QIS Matrix and descriptors (appendix 1) to assess the likelihood of the risk occurring and the impact it would have and determine the overall level of the risk.	Impact/Consequence (use descriptor relevant to proposal and select level of impact)	Likelihood	Rating R= I/C x L
Initial Risk Rating	Extreme	Unlikely	High
Target Movement	↔	↔	↔
Target Risk Rating	Extreme	Rare	Medium
Current Risk Rating	Extreme	Unlikely	High

Further control measures required	Include any additional controls identified to eliminate or reduce the risk further.
• Security refresh project underway, completion April 2022 December 2021 Update: • Patients fully risk assessed for grounds access. • All patients searched prior to entering grounds • Increase review of patients grounds access following behavioural incidents during this time. • Remove use of patio areas during fence line work weekdays only. • Move to centralised grounds access weekdays only • Control Room to closely monitor surrounding areas of work. • Escorting and contractor staff to be fully briefed regarding patients observing them at work. • Escorting staff reminded to be vigilant towards the risk of patients approaching. • Protocol for patient approach created. • At height equipment can be made immobile quickly by operator and lowered to a negligible height within 20 seconds. • If equipment failure takes place and immediate withdrawal of grounds access will be implemented by the control room. Escorted movement will only be allowed during this time following risk assessment by security. • Ensure Responder Model is maintained. With all the added controls in place the likelihood is significantly reduced. The only time the risk may be HIGH is if the equipment fails at height. This is covered by the protocols and controls above to mitigate such an event.	

Assurances	What assurances are there that current controls are effective? (Internal and external)
Security Audit undertaken September 2020. Action to be monitored by • Security Risk and Resilience • Daily Grip meeting (Director attendance) • Weekly Review of Risk at Incident Command Meeting • Bi-monthly report to Board on Corporate Risk Register.	

Corporate Objective		Tick the box to indicate the corporate objective the risk aligns with
Better Care	✓	
Better Health		
Better Value		
Better Workforce		

Date Added to CRR	February 2016
Completed by	David Walker
Last reviewed:	10/12/21
Next review:	01/01/22 (or before)

Complete this section if risk is being escalated to risk register then refer to risk register guidance for next steps

Group monitoring risk	Security Risk and Resilience Group and Incident Command Team

Key Performance Indicators	Detail any existing KPIs that would link to risk, and show performance against risk
• Patient incidents within wards and grounds relative to subverting security • Daily monitoring of Security systems. • Mechanical Equipment failure • Responder model compliance • Search compliance	