THE STATE HOSPITALS BOARD FOR SCOTLAND

BOARD MEETING

THURSDAY 22 OCTOBER 2020
at 9.45am, 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 meetings held on 27 August 2020	For Approval	TSH(M)20/07
4.	**Matters Arising:**		
	Actions List: Updates	For Noting	Paper No. 20/61
5.	**Chair's Report**	For Noting	Verbal
6a.	**Chief Executive Officer's Report**	For Noting	Verbal
b.	**Update on EU Withdrawal** Report by the Director of Security, Estates and Facilities	For Noting	Presentation
10.05am	**COVID-19 RESPONSE**		
7.	**Covid 19 Response:**		
a.	**Board Governance – six month review** Report by the Chair	For Decision	Paper No. 20/62
b.	**Remobilisation Plan** Report by the Chief Executive	For Noting	Paper No. 20/63
c.	**Resilience Update** Report by the Chief Executive	For Discussion	Paper No. 20/64
d.	**Financial Update** Report by the Finance & Performance Management Director	For Noting	Paper No. 20/65
10.50am	**CLINICAL GOVERNANCE**		
8.	**Person Centred Improvement – 12 Month Report** Report by the Director of Nursing and AHPs	For Noting	Paper No. 20/66

9.	**Medical Appraisal and Revalidation Annual Report 2019/20** Report by the Medical Director	For Noting	Paper No. 20/67
10.	**Quality Assurance and Improvement** Report by the Head of Corporate Planning and Business Support	For Noting	Paper No. 20/68
11.	**Clinical Governance Committee** Chair's Update - meeting held 13 August 2020	For Noting	Verbal
11.20am	**STAFF GOVERNANCE**		
12.	**Attendance Management Report** Director of Human Resources	For Noting	Paper No. 20/69
13.	**Staff Governance Committee** Chair's update - meeting held 20 August 2020	For Noting	Verbal
11.40am	**CORPORATE GOVERNANCE**		
14.	**Internal Audit Review** Report by the Finance & Performance Management Director	For Decision	Paper No. 20/70
15.	**Internal Audit – Board Pack Quality Assessment** Report by RSM UK	For Noting	Paper No. 20/71
16.	**Perimeter Security and Enhanced Internal Security Systems Project - 12 Month Report** Report by the Director of Security, Estates and Facilities	For Noting	Paper No. 20/70
17.	**Finance Report to 30 September 2020** Report by the Finance & Performance Management Director	For Noting	Paper No. 20/71
18.	**Risk Management Annual Report 2019/20** Report by the Finance & Performance Management Director	For Noting	Paper No. 20/72
19.	**Communications – Annual Report 2019/20** Report by the Head of Communications	For Noting	Paper No. 20/73
20.	**Annual Review - update on process 2019/20** Report by the Board Secretary	For Noting	Paper No 20/74
21.	**Corporate Governance Blueprint** Report by the Board Secretary	For Noting	Paper No 20/75
22.	**Audit Committee** Approved Minutes - meeting held 18 June 2020, 2 July Chairs Update - meeting held 8 October 2020	For Noting	AC(M) 20/03 AC(M) 20/04 Verbal
23.	**Corporate Risk Register** Report by the Finance & Performance Management Director	For Discussion	Paper No. 20/78
24.	**Board and Committee Schedule 2021** Report by the Board Secretary	For Decision	Paper No. 20/79

25. **Any Other Business**

26. **Date of next meeting**
17 December 2020

12.40pm **End of meeting**

THE STATE HOSPITALS BOARD FOR SCOTLAND TSH (M) 20/07

Minutes of the meeting of The State Hospitals Board for Scotland held on Thursday 27 August 2020,

Meeting conducted virtually by way of MS Teams and commenced 11.40am.

Chair: Terry Currie

Present:

Non-Executive Director	Bill Brackenridge
Employee Director	Tom Hair
Chief Executive	Gary Jenkins
Non-Executive Director	Nicholas Johnston
Vice-Chair	David McConnell
Director of Finance and Performance Management	Robin McNaught
Non-Executive Director	Brian Moore
Director of Nursing and AHPs	Mark Richards
Medical Director	Lindsay Thomson

In attendance:

Head of Communications	Caroline McCarron
Head of Corporate Planning and Business Support	Monica Merson
Board Secretary	Margaret Smith *(Minutes)*
Director of Security, Estates and Facilities	David Walker
HR Director	John White

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

Mr Currie welcomed everyone to the meeting, and no apologies were noted. He acknowledged that today's meeting was being conducted virtually by way of MS Teams.

2 CONFLICTS OF INTEREST

There were no conflicts of interest in respect of the business on the agenda.

3 MINUTES OF THE PREVIOUS MEETING

The Minutes of the previous meetings held on 18 June and 2 July 2020 were noted to be accurate records of each meeting.

The Board:

1. Approved the minute of the meetings held on 18 June and 2 July 2020: TSH(M)04 and TSH(M)05.

4 ACTION POINTS AND MATTERS ARISING FROM PREVIOUS MEETING

The Board received the action list (Paper No. 20/45) and noted progress on the action points from the last meeting, with actions being progressed satisfactorily within the context of the current response to COVID-19. It was noted that progress in respect to some actions had not been possible for this reason and these actions would be carried forward for update at the next Board meeting.

The Board:

1. Noted the updated action list.
2. Noted that outstanding actions would be carried forward for update.

5 CHAIR'S REPORT

Mr Currie provided an update from a meeting of NHS Chairs' Group with the Cabinet Secretary for Health and Sport, which had taken place on 22 June and on 24 August 2020.

At the Chairs Meeting with the Cabinet Secretary on 22 June 2020, the Cabinet Secretary thanked NHS Chairs for their leadership and support in meeting the challenges of the Covid-19 pandemic. She also underlined the importance of proceeding with caution when reinstating services and to be mindful of the possibility of spikes of infection. NHS Chairs also discussed Test & Protect, contact tracing and care homes, as well as receiving an update on mental health service provision from the Minister for Mental Health, Clare Haughey. At the meeting on 24 August, the Cabinet Secretary highlighted the importance of public messaging regarding emergency and other services, and main challenges over the coming months particularly with local clusters, Test and Protect capacity, implementing remobilisation plans, and the need to increase uptake of the seasonal flu vaccination by staff.

High on the agenda at Scottish Government meetings was the implementation of Board remobilisation plans and the need to be prepared for a second wave of the pandemic, plans for primary care, and discussions around scope of reinstating of services.

In terms of The State Hospital, the Board noted that Non-Executive recruitment had now re-commenced, and the recruitment process for the three non-executive posts, currently either vacant or nearing end of term, at The State Hospital had begun. The State Hospital's Annual Review would take place on 10 November 2020 by video conferencing and would be a Ministerial Review attended by the Chair and Chief Executive.

The Board:

1. Noted this update from the Chair.

6 CHIEF EXECUTIVE'S REPORT

Mr Jenkins provided an update to the Board on key national issues, since the date of the last Board meeting. He advised that key focus for NHS Chief Executives was on remobilisation and recovery of NHS Scotland, in a clinically prioritised way. There would continue to be focus on leadership of care homes especially governance arrangements. Over the longer term, NHS Scotland "recovery and renewal" would be key aspects for a healthier Scotland. He asked the Board to note that Scottish Government were scheduling meetings with each Health Board in September/ October in relation to financial governance.

Mr Jenkins confirmed that he was directly involved in remobilisation of mental health care alongside the CEO of NHS Grampian, Ms Amanda Croft and the Director of Nursing at NHS Lothian Mr Alex

McMahon as well as the Director of Strategic Planning, Mr Colin Briggs. This group was looking at the key challenges for the delivery of mental health in the context of additional demand for mental health support in the wider context of the impacts of the pandemic.

He emphasised that The State Hospital (TSH) remains in alignment with the key themes in remobilisation for NHS Scotland as a whole.

.

The Board:

1. Noted the update from the Chief Executive

7a RESILIENCE REPORTING – COVID 19 RESPONSE

A paper was received from the Chief Executive (Paper No. 20/46) to provide the Board with the background and framework through which TSH was continuing to manage its response to Covid-19, and to provide key updates to the Board on actions taken since the date of the last Board meeting.

Mr Jenkins confirmed the draft Remobilisation Plan for TSH for the period from September 2020 to 31 March 2021 had been submitted to Scottish Government on 7 August, and that a response was expected from the Cabinet Secretary for Health and Sport.

Mr Jenkins then led the Board through a detailed overview of the resilience report, noting that existing Board governance arrangements have continued throughout the pandemic, and acknowledging the national framework of Active Governance being led through the Corporate Governance Steering Group. In this context, there would be a dedicated Board Seminar to allow reflection of governance arrangements in the near future.

He asked Board Members to note the update in reference to the de-brief session which had taken place on 7 August in relation to the structure and operation of the Gold and Silver Command structure, and that this had been useful to help focus on key learning. He confirmed that guidance on the extension of the NHS emergency footing period, was awaited form Scottish Government and this would allow consideration of the continuation of incident command at a local level. He underlined the continuing focus of the TSH Scientific and Technical Advisory group (STAG) in providing rigorous review process for enhanced health surveillance, national guidance and literature. Board Members continued to receive regular updates confirming the continuation and impact of the Interim Clinical Operational Policy which remained under continuous review and scrutiny.

Mr Jenkins highlighted that infection control remained central to the success in TSH in infection prevention and spread, and confirmed that the Infection control committee had re-started. He highlighted the pathway taken in respect of test and trace within TSH, and how mass testing in the event of an outbreak would be conducted. In respect to PPE, Mr Jenkins confirmed that TSH had not experienced any significance supply difficulty.

He advised that in-person visiting had recommenced in the week beginning 13 July 2020, in accordance with the national framework, and was effectively supporting patient contact with families and carers. In addition, video-visiting provided another means of contact.

Mr Jenkins asked the Board to note the data included in reporting with respect to staff attendance management and the resilience maintained in staffing throughout. Mr White added his assurance that good progress was being made to support those staff who had been shielding to return to work. Mr Jenkins advised that recruitment initiatives were being actively taken forward to ensure continued resilience across the organisation. He underlined the importance of supporting staff health and wellbeing and the local measures put in place including the staff wellbeing zone.

Mr Jenkins noted the reduction in completed Personal Development and Performance Reviews, due to the national pause in this workstream. This had now re-started and line and managers and staff would be supported to refocus on this important area.

The report also outlined the progress made by the Recovery and Innovation Group, and the key components of engagement with patients, carers and staff. This had been a positive and worthwhile exercise to help support the recovery process. Mr Jenkins praised the support in staff engagement through Communications which had been an essential element as well as the good progress made in digital ways of working supported by eHealth.

Mr McConnell queried the sickness absence rate, and it was confirmed by Mr White that there could be variance experienced in the local data recorded by SSTS and the national figure produced through SWISS – the correct data for the purposes of reporting was 5.61%.

In response to a question from Mr Moore on funding of newly recruited nursing staff, Mr Richards confirmed that the additional financial pressure, due to the response to Covid-19, had been submitted to Scottish Government as required; and also noted the longer term funding position within the existing directorate budget.

There was discussion round the de-brief session held on the operation and impact of the Incident Command Structure, with agreement that the longevity required had not been foreseen at the outset but had come to be understood as necessary as a resilience response by the organisation. The session had outlined a full range of views from across the organisation and highlighted areas for learning.

Mr Currie summarised the discussion on behalf on the Board, in relation to this report emphasising the exemplary nature of internal communications throughout the pandemic as well as the contribution made by staff. He noted the low levels of sickness absence experienced as well as the robust nature of monitoring of the Interim Clinical Operations Policy. He advised that the Cabinet Secretary had wished to see positive evidence of NHS Boards providing strategic leadership and operational competence, and that the Board considered that the Chief Executive and wider executive team had demonstrated this successfully throughout these months. With agreement around the table, he confirmed that the Board was content to note this report and to endorse the strategic way forward for remobilisation of the organisation.

The Board:

1. Discussed and noted the position outlined in this report in respect to the operational management and governance of the organisation in response to the global Covid-19 outbreak.

2. Endorsed the position as an appropriate framework for continued operational management and governance during the Covid-19 pandemic.

3. Confirmed that there were no additional addition reporting requirements required at this stage.

7b COVID -19 RESPONSE - FINANCIAL GOVERNANCE

.

A paper was received from the Finance and Performance Management Director (Paper No. 20/47) to provide an update on financial governance during the Covid-19 pandemic.

Mr McNaught provided an overview for the Board confirming that Covid-19 costs for quarter 1 April to June 2020) were submitted to Scottish Government in mid-August, including staff overtime costs, set up of the dedicated Covid Support Team as well as additional nursing recruitment and IT equipment.

Mr Currie confirmed the Board's positon as content with this update on financial governance, and to await further reporting at the next meeting of the Board.

The Board:

1. Noted the updated advice on financial governance through the Covid-19 pandemic.

8 PATIENT, CARER, VOLUNTEER STORIES

Mr Richards introduced a presentation to the Board from the Patient Centred Improvement Team, underlining the continued importance of listening to the views of patients. Ms Dickson and Ms Tennant joined the meeting and asked members to listen to a recording from a patient telling his story. The patient described how he had contracted Covid-19 at the beginning of the spread of the pandemic, and how he had felt lonely and worried. Even though his physical symptoms had been mild, he still felt scared about how it could impact him and found a lack of information and isolation increased this. He found the reduced interaction with staff difficult and made him feel that staff were detached. Once he was no longer in isolation, he found he could cope better and enjoyed the banter he had with staff. It had been a difficult experience for him but he did understand that the hospital had to take these steps so that there was no risk to others.

Ms Dickson picked up on the patient's experience and outlined some of the learning and specific actions taken to support patients including patient information leaflets, and a weekly patient communications to make sure patients were being kept up to date. Patient feedback indicated that this had helped to support patients through this experience and to reduce anxieties. She also presented an image of the Graffiti Wall created by patients to capture their feelings.

This presentation was received very warmly by the Board. In particular, Mr Johnston commented on how much he valued hearing from patients directly, and that this patient story helped to focus on the positive work undertaken in the hospital. Mr Currie summarised for the Board, emphasising the importance of this patient feedback and giving thanks to the Person Centred Improvement Team for their work.

The Board:

1. Noted the value and importance of the presentation including the patient story.

9 MEDICAL EDUCATION ANNUAL REPORT – 12 MONTHLY REPORT

A paper was received from the Medical Director (Paper No. 20/48) which provided the Board with an assessment of the undergraduate and postgraduate training undertaken at TSH during the period 1 August 2018 to 31 July 2020. This provided assurance to the Board for governance of medical education in the context of General Medical council (GMC) standards in this regard.

Professor Thomson led Members through the detail of the paper, underlining the continuing high standard of medical education within the hospital and highlighting the award of Good Practice Recognition from NHS NES, which marked the good esteem with which training at TSH was held. She noted that in recent months the Journal Club had been paused and had been greatly missed; this was now restarting through digital means.

Board Members received this report positively, and Mr Currie noted that this continued to be an area of great strength which the Board was happy to receive and note.

The Board:

2. Noted the content of the report and continued high standard of undergraduate and

postgraduate medical training provided by TSH, and the adaptations made during the pandemic as well as the short term challenge to resilience in the first tier medical on call rota as outlined.

10 DUTY OF CANDOUR ANNUAL REPORT 2019/20

A paper was received (Paper No. 20/49) from the Medical Director, which outlined the actions taken by TSH during 1 April 2019 to 31 March 2020, to implement duty of candour legislation and good practice.

Professor Thomson summarised the report indicating that the numbers of incidents considered as potentially being duty of candour had reduced considerably since the previous year and this had been expected as part of the cautious approach taken. There had been one incident that was considered to have fulfilled the criteria for duty of candour, and Professor Thomson confirmed that this had been investigated appropriately and learning taken.

Board Members did not raise any concerns with the content of the report. Mr Currie summarised by noting that the Clinical Governance Committee retained close oversight in this area, and that the Board was content to note this update.

The Board:

3. Noted the content of this update.

11 QUALITY ASSURANCE AND IMPROVEMENT REPORT

A paper was received from the Head of Corporate Planning and Business Support (Paper No. 20/50) to give the Board a regular update on the progress made toward quality assurance (QA) and Quality Improvement (QI) activities.

Ms Merson provided a summary of activity since the date of the last Board meeting including clinical audit, learning from complaints and feedback and Service Reports. She highlighted the activity of the TSH Quality Forum in supporting the Recovery and Innovation Group in the remobilisation of the hospital. She also asked the Board to note the robust process and evaluation matrix used within TSH to measure compliance with national and local evidence based guidelines and standards, and continued progress on capacity building to support QA and QI within TSH.

Board Members welcomed this report and noted the usefulness of its content with quality assurance and improvement a primary function of the organisation. The Board was pleased to learn that the Quality Forum's TSH3030QI project team had been shortlisted for Psychiatric Team of the Year by the Royal College of Psychiatrists. Mr Currie summed up by noting the comprehensive nature of reporting and the great success achieved.

The Board:

1. Noted the content of the report.
2. Asked for reporting to continue to the Board at each meeting.

12 IMPLEMENTATION OF SPECIFIED PERSONS – ANNUAL REPORT

A paper was received from the Director of Security, Estates and Facilities (Paper No. 20/51) which provided the Board with an annual report on the implementation of the specified person regulations at the TSH, under the terms of the Mental Health (Care & Treatment) (Scotland) Act 2006.

Mr Walker summarised the key points for the Board, advising that the data did not vary greatly from reporting in previous years. He noted that the data was routinely reported in more detail through the Clinical Governance Committee.

The Board approved the report for submission to Scottish Government as outlined in the report.

13 CLINICAL GOVERNANCE COMMITTEE

The Chair of the Clinical Governance Committee, Mr Johnston asked the Board to note the approved minutes [CGC (M) 20/02] of the meeting of the Clinical Governance Committee which took place on 14 May 2020.

The Board:

1. Noted the content of the approved minutes.

14 STAFF GOVERNANCE COMMITTEE – STAFF SIDE REPRESETATION

The Board received a paper (Paper No. 20/52) outlining a proposal from the Staff Governance Committee to increase staff side representation from two to three members, as a further supportive mechanism for partnership working in the organisation. There was agreement around the table and Mr Currie noted that this proposal was approved.

The Board:

1. Approved an amendment to the terms of reference of the Staff Governance Committee to add a third staff representative.

15 STAFF GOVERNANCE COMMITTEE

The Chair of the Staff Governance Committee, Mr Brackenridge, asked the Board to receive the approved minutes of the meeting held on 28 May 2020 (SGC (M) 20/01).

The Board:

1. Noted the approved minutes of the Staff Governance Committee meeting held on 28 May 2020.

16 PERIMETER SECURITY AND ENHANCED INTERNAL SECURITY SYSTEMS PROJECT

A report was received from the Director of Security, Estates and Facilities (Paper No. 20/53) which summarised the current status of the Perimeter Security and Enhanced Internal Security Systems Project.

Mr Walker provided an update to Board Members, highlighting the continued expectation of a completion date if 15 October 2021. Mr Irwin joined the meeting to assist in summarising the progress of works completed or underway to date. It was agreed through discussion that it would be of assistance to Board Members to receive a further presentation as part of the next Board Seminar, allowing further detailed exploration of progress.

On behalf of the Board, Mr Currie noted contentment with this update and for the session to be arranged in the near future, as this was an area of key focus for the Board.

The Board:

1. Noted the content of this report.

17 FINANCE REPORT AS AT 30 JUNE 2020

A paper was submitted to the Board (Paper No. 20/54) by the Finance and Performance Management Director, which presented the financial position to month 3 (30 June). Mr McNaught led Members through the report highlighting the key areas of focus and confirmed that TSH was reporting an underspend at this date of £90k. The key focus was currently the confirmation of Covid19 specific costs for review through Scottish Government, and reducing the levels of unidentified savings for the coming year.

In response to a query from Mr McConnell on unidentified savings, it was noted that clarification should be made to section 4.1 to recognise the quarter one position.

Action – Mr McNaught.

Mr Currie confirmed that the Board were content to note this paper, subject to the minor amendment indicated.

The Board:

1. Noted the content of this report.

18 PERFORMANCE REPORT – QUARTER 1 – 2020/2021

A paper was received (Paper No. 20/55) Director of Finance and Performance Management to provide a high-level summary of organisational performance during quarter one of the current financial year. Ms Merson provided a summary of the key points of the report, focussed on the performance indicators in the Red-Amber–Green (RAG) reporting either as Red or Amber.

She advised that work was continuing to progress on performance reporting to ensure that an improved information assurance framework was in place and regularly reported to the Board. On this point it was agreed that the next Board Seminar would afford an opportunity to review progress in the context of the national Active Governance workstream.

Action – Ms Smith/ Ms Merson

The Board:

1. Noted the content of this report.

19 CORPORATE RISK REGISTER

The Board received a paper (Paper No. 20/56) from the Finance and Performance Management Director, 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 McNaught provided a summary of the report for the Board noting that one risk – that of Covid-19 – was rated as Very High with six further risks noted as High.

Mr Currie summarised that the Board noted the report and did not consider that discussion at today's meeting had indicated that any further amendment or addition should be made to the Corporate Risk Register.

The Board:

1. Noted the content of this report

20 ANY OTHER BUSINESS

There were no further items of business for consideration.

21 DATE AND TIME OF NEXT MEETING

The next meeting would take place on Thursday 22 October 2020, by way of MS Teams.

The meeting ended at 1.30pm

ADOPTED BY THE BOARD

CHAIR

(Signed Mr Terry Currie)

DATE

THE STATE HOSPITALS BOARD FOR SCOTLAND
ROLLING ACTION LIST

ACTION NO	MEETING DATE	ITEM	ACTION POINT	LEAD	TIMESCALE	STATUS
1	February 2020	Clinical Service Delivery Model (item 7)	Update on key milestones for delivery – overall financial monitoring and recording on Corporate Risk Register.	R McNaught/ M Merson	April 2020 – paused	**Paused: due to Covid-19**
2	February 2020	Annual Operational Plan (Item 16)	Reflect content of AOP in governance committee workplans	M Smith/ Committee Chairs/ Exec Leads	Ongoing	**Annual Operational Plan paused due to Covid-19. To be agreed by Board that Remobilisation Plan (September to March 2021) to be reflected in governance committee workplans.**
3	February 2020	Corporate Governance Improvement Plan (Item 21)	Review engagement plan for Board in holding meetings externally	G Jenkins/ M Smith/ C McCarron	Ongoing	**Update: Report to Board on agenda to restart process, and to be reviewed at Board Seminar in November.**
4	August 2020	Finance Report to 30 June	Amendment to report in respect of unidentified savings, for clarity.	R McNaught	Immediate	**Completed**

5	August 2020	Performance Report Quarter 1 2020/21	Performance metrics/ reporting to be included on agenda for Board Seminar (as part of Active Governance)	M Merson/ M Smith	Immediate	**<u>Completed</u>** **Agreed as on agenda for Board Seminar 4 November**

Updated – 14.10.20

Author:
Margaret Smith
Board Secretary
01555 842012

Board Paper 20/62

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 October 2020
Agenda Reference:	Item No: 7a
Sponsoring Director:	Board Chair
Author(s):	Board Secretary
Title of Report:	Board Governance – Six Month Review
Purpose of Report:	For Decision

1 SITUATION

In March 2020, and as a result of the Covid-19 pandemic, all NHS Boards were asked to carry out a review of corporate governance.

2 BACKGROUND

On 25 March 2020, Scottish Government Health Finance, Corporate Governance & Value Directorate advised that effective governance should be maintained in NHS Boards, though acknowledged that this could be different from the existing structures in place. The State Hospitals Board for Scotland (TSH) carried out a review of the corporate governance framework for the NHS Board to ensure effective oversight during the Covid-19 pandemic.

This review was conducted within the requirement of existing legislation, and in reference to the existing Standing Orders of the Board. The aim was also to identify new emerging risks within the corporate governance framework as well as options to mitigate these risks. A report was prepared and circulated to Board Members on 30 March 2020, and this is attached **(Appendix A).**

On 1 April 2020, The State Hospitals Board for Scotland (TSH) submitted a report to Scottish Government on its review of the corporate governance framework for the NHS Board to ensure the continuation of effective oversight.

It was agreed at the Board meeting on 23 April 2020, that this position should be reviewed by the Board within six months, or sooner should the global pandemic situation change significantly.

Therefore, it is now timely for the Board to consider and review this position.

3 ASSESSMENT

The long term nature of the pandemic and continued potential impact means that the Board should consider whether the conclusions of the review undertaken at the outset are still applicable, and whether any adjustment should be made at this stage.

The recommendations of the report can be summarised as follows:

1) Board Meetings should continue on agreed schedule, and that special meetings can be convened as required. The business transacted at the Board will be reviewed to allow oversight of the Covid-19 response as well as resilience of the senior leadership team to provide reporting to the Board during this challenging time.

2) Governance Committee meetings should be critically reviewed and may be paused depending on the emergent situation in managing the response to Covid-19. If the situation arises where a meeting is not quorate then it would be the intention to reschedule to the earliest possible date.

3) Any divergence from the agreed workplans for the Board and its Committees, should be recorded in the minutes of the meeting appropriately.

4) The Board should note the risk to achieving required quorum for Board and committee meetings.

5) All Board and committee meetings should be held virtually by way of teleconferencing.

6) There is no requirement to amend existing Standing Orders.

7) This position should be reviewed by the Board in six months' time, or sooner should the global pandemic situation change significantly.

The Board has continued to meet during 2020 according to its planned schedule, with an additional meeting arranged for 2 July 2020 to approve end of year reporting for 2019/20. Meetings have all been held virtually with migration from teleconferencing to MS teams, and the resulting attendance by the Board has been extremely high. Similarly, the governance committees have met according to their existing schedules, also migrating to virtual meetings by MS teams, and with similarly high attendance rates. Recommendation (5) should be updated to reflect that meetings are now held by way of MS Teams.

The focus of agendas for each board and committee meeting have been considered and adjusted appropriately to reflect the ongoing pandemic and the response required. This has enabled oversight of the response to Covid-19 by the Board and its committee structure, with the senior leadership team demonstrating key resilience in the provision of a highly detailed level of reporting.

Scottish Government requested a comparative review of the positions taken across NHS Boards during 2020, and has commissioned the NHS Chairs Group, through its sub-group the Corporate Governance Steering Group, to take forward learning through the 'Active Governance' workstream. This is focussed on developing and underpinning existing progress made through the Blueprint for Good Governance. This workstream is now restarting at The State Hospital, with a focused approach being taken through scheduling of a Board Seminar in this respect, on 4 November 2020. There is national focus on how to support public attendance at board meetings, with further guidance awaited to provide coherence and a 'Once for Scotland' approach.

4 RECOMMENDATION

The Board is invited to review its existing governance arrangements, and to indicate any adjustments it considers should be made for the next six month period. The migration to MS

Teams and national focus on public inclusion is noted, and it is recommended that the Board awaits national guidance in this respect.

Author:
Margaret Smith
Board Secretary
01555 842012

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	To support a six month review of board governance during the Covid-19 pandemic
Workforce Implications	No wider implications identified, specific potential resilience impact on leadership and teams outlined.
Financial Implications	None directly considered.
Route To Board Which groups were involved in contributing to the paper and recommendations?	Board requested as six month review
Risk Assessment (Outline any significant risks and associated mitigation)	Risk to Board and Committee governance schedule and require reporting outlined.
Assessment of Impact on Stakeholder Experience	No specific impact
Equality Impact Assessment	Not required.
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	Not applicable.
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One X There are no privacy implications. □ There are privacy implications, but full DPIA not needed □ There are privacy implications, full DPIA included.

Appendix A

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	30 March 2020 - Circulated by email
Agenda Reference:	Item No: N/A
Sponsoring Director:	Chief Executive Officer
Author(s):	Board Secretary
Title of Report:	Corporate Governance Arrangements during Public Health Emergency – Covid 19
Purpose of Report:	For Decision

2 SITUATION

The State Hospital (TSH) faces an unprecedented situation due to the Covid-19 public health emergency. The challenge presented is global and is continually changing at a rapid pace.

In this situation, a review of the corporate governance framework for the NHS Board is required to ensure effective oversight during the coming months.

2 BACKGROUND

On 25 March 2020, Scottish Government Health Finance, Corporate Governance & Value Directorate advised that effective governance will need to be maintained, though this may be different from the structures currently in place. It is acknowledged that changes to existing corporate governance arrangements may be necessary at this time, and advised that any proposed change should, for good governance reasons, be presented to the Board as quickly as possible.

Whilst acknowledging that no single approach will fit all NHS Boards, Scottish Government have advised that any change to governance should:

- enable agile and effective decision-making;
- place staff and their resilience at the centre;
- build important links with the public and community at this time;
- Ensure that Boards operate in an open and transparent way to enable public scrutiny.

The review should be conducted within the requirement of existing legislation, and in reference to the existing Standing Orders of the Board. Further, to identify new emerging risks within the corporate governance framework and options to mitigate these risks.

3 ASSESSMENT

In a fast moving situation, it is imperative that the Board continues to be able to meet the challenges presented by the Covid-19 pandemic; and to meet its governance responsibilities. The key factors in consideration are outlined as follows.

Oversight of Covid-19 Response

The Board currently meets bi-monthly, on the third Thursday of the month and is due to meet on the following dates over the next six months: 23 April, 18 June and 27 August 2020.

In addition, Standing Orders state that:

"The Chairperson may call a special meeting of the Board at any time as required or on receiving a requisition in writing for that purpose signed by one third of the whole number of Members of the Board (including at least two non-executive Members)."

Therefore, it is proposed that the agreed schedule of Board Meetings remains in place and that existing Standing Orders allow sufficient flexibility for further special meetings to be called if required thus enabling scrutiny and oversight of the response to Covid-19. This will continue to support agile and effective decision-making by the Board.

Resilience of Senior Leadership

There is a risk that the current arrangements for the Board and its Standing Committees are not flexible enough to allow the organisation to meet an escalating crisis most effectively. This takes cognisance of whether the Chief Executive and Executive Team, Senior Management Team, Board Secretary and wider administrative function can be in a position to adhere to the current arrangements, whilst at the same time actively engaging in the urgent requirements of managing the Covid-19 response through the TSH Covid-19 Command Structure. Therefore, there should be ongoing critical review of Board and Governance Committee business, with particular attention to agenda setting over the course of the next six months.

The Staff Governance Committee, the Clinical Governance Committee and the Audit Committee meet quarterly. The Remuneration Committee meets as required. It is not recommended that these Committees be paused at this point but that the need for each committee to take place should be kept under review over the course of the next six months. Meetings may need to be deferred or the business conducted reduced during this period of time, prioritising any agenda items which require specific and timely approval.

Agenda setting for the Board and Committee meetings should be considered in the context of managing the Covid-19 response and in line with the agreed Board and Committee workplans. Any change to the meeting schedule or the agendas can be audited through the Board minutes; or through the Committee minutes which are reported to the Board.

The agendas for the Audit Committee and Board meetings of 18 June include a number of items focussed on the financial year-end and the annual accounts review and sign-off. Currently we are still progressing towards the 31 March financial close, with accounts submission for 30 June in line with the original year-end / audit timetable. However, this position is under review at Scottish Government / NHSScotland level, and may change in the coming weeks with possible options including a later accounts submission deadline, or an abbreviated form of reporting and audit review, or other alternatives not yet disclosed. Should this be the case, then our governance meetings will be required to be amended accordingly to suit any new timescale?

Conduct of Board and Committee Meetings

Consideration must be given to the health and well-being of Members of the Board and Committees as well as wider attendees should meetings continue to be held in a face to face basis; and also for any member of the public in attendance at Board Meetings.

A key risk will be that meetings do not achieve their quorum due to illness within the membership, meaning that decision-making may need to be deferred. Existing Standing Orders stipulate quorum for the Board to be at least one third of Members, and two of which should be Non-Executive Members. In practical terms this is four Members, two of which are Non-Executives. It is considered that this allows sufficient flexibility for the transaction of business, even at this challenging time.

The Public Bodies (Admission to Meetings) Act 1960 required Board Meetings to be held in public. However under Section 1(2) the Act sets out circumstances win which the public can be excluded.

"Whenever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons".

In these circumstances, a resolution can be passed allowing the public to be excluded. All NHS Boards have legal responsibilities to protect public health, and current U.K. Government and Scottish Government advice on social distancing means that it would not be appropriate to convene Board Meetings publically. This would also avoid all but essential travel.

The existing Standing Orders state that:

"*The ordinary meetings of the Board shall, unless the Board otherwise agrees, be held on the third Thursday of every second month at the State Hospital, Carstairs or at such place and at such time as the Board shall determine*".

It is considered that this description gives sufficient flexibility to allow Board Meetings to take place virtually by way of teleconferencing or videoconferencing, and the decision to do so can be recorded in the minutes of the meeting.

Board Meeting papers, including Board and Committee minutes, are routinely published through the organisation's website and this practice should continue to encourage public engagement and scrutiny.

4 RECOMMENDATION

The Board is invited to <u>agree</u> that:

8) Board Meetings should continue on agreed schedule, and that special meetings can be convened as required. The business transacted at the Board will be reviewed to allow oversight of the Covid-19 response as well as resilience of the senior leadership team to provide reporting to the Board during this challenging time.

9) Governance Committee meetings should be critically reviewed and may be paused depending on the emergent situation in managing the response to Covid-19. If the situation arises where a meeting is not quorate then it would be the intention to reschedule to the earliest possible date.

10) Any divergence from the agreed workplans for the Board and its Committees, should be recorded in the minutes of the meeting appropriately.

11) The Board should note the risk to achieving required quorum for Board and committee meetings.

12) All Board and committee meetings should be held virtually by way of teleconferencing.

13) There is no requirement to amend existing Standing Orders.

14) This positon should be reviewed by the Board in six months' time, or sooner should the global pandemic situation change significantly.

Paper No. 20/63

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 October 2020
Agenda Reference:	Item No: 7b
Sponsoring Director:	Chief Executive
Author(s):	Board Secretary
Title of Report:	TSH Remobilisation Plan
Purpose of Report:	For Discussion

1 SITUATION

At its meeting on 2 July 2020, the Board received the TSH Interim Remobilisation Plan for the period to August 2020. The Board is now asked to consider the TSH Remobilisation Plan for the period September 2020 to March 2021.

2 BACKGROUND

In response to guidance from the Cabinet Secretary for Health and Sport, and in line with other National Boards, The State Hospital (TSH) submitted a draft Remobilisation Plan to Scottish Government on 7 August 2020. Territorial Boards were required to submit Remobilisation Plans by 31 July 2020. This plan has now been approved to be published following this meeting of the Board.

3 ASSESSMENT

The Remobilisation Plan describes in detail planning for The State Hospital (TSH), as a unique service within NHS Scotland whilst aligning with the national framework and engaging with other National Boards and NHS Scotland Forensic Mental Health Services.

The Remobilisation Plan provides focus for the continued response to Covid-19 for TSH during this period, and the delivery of person-centred care for our patients. The plan demonstrates continued focus on clinical care through the monitoring framework instituted to review the impact of the Interim Clinical Operations Policy. The plan places this within the context of the importance infection control and reducing the risk of nosocomial infection at TSH, as well as the implementation of test and trace methodology. The Remobilisation Plan also focuses on the wider well-being of patients through video-visiting to enable contact with families and carers.

The Board is asked to note the work progressed to help inform remobilisation through engagement with staff, patients, carers and volunteers. Further, the mechanisms in place for supporting staff

wellbeing during this challenging period. Remobilisation planning will continue recognise the positive nature of partnership working and to support remobilisation and the formation of the 'new normal' for The State Hospital.

The indicative schedule to restart workstreams is on a phased basis across the hospital is described and this process continues to be led by Gold Command. Plans for the re-establishment of activities will require to be risk assessed in line with each phase, and underpinned by infection control guidelines and expert public health advice. The timescale for each phase remains fluid, dependant on the rate of infection in Scotland.

Remobilisation Planning prioritises digital transformation across TSH to build on the progress already made to date.

There is recognition of the need to modify TSH resilience planning as previously outlined in the Annual Operational Plan and arrangements due to the impact of Covid-19

Financial Implications are an integral part of remobilisation planning, and financial planning sets out the resources available within context of regular funding assumptions. The financial plan is balanced and delivery of a breakeven position during 2020/21 remains dependent on recognition of Covid-19 funding pressures, and realisation of the savings plan.

The corporate governance framework has been reviewed to ensure effective oversight during the Covid-19 pandemic, with cognisance taken of the 'Active Governance' workstream being take forward nationally through the Corporate Governance Steering Group, and which will build upon progress already made through implementation of the Blueprint for Good Governance. This will be reviewed by the Board at a Seminar arranged for 4 November 2020.

The Board will be provided with assurance at each meeting relating to progress throughout this phased remobilisation process.

4 RECOMMENDATION

The Board is invited to note and discuss the TSH Remobilisation Plan.

Author:
Chief Executive - Gary Jenkins

Contact:
Margaret Smith
Board Secretary
01555 842012

Paper No. 20/63
MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives?	In support of Scottish Government requirement for NHSScotland remobilisation
Workforce Implications	Assessed within the Remobilisation Plan
Financial Implications	Assessed within the Remobilisation Plan
Route to the Board (Committee) Which groups were involved in contributing to the paper and recommendations?	Board required / in support of Scottish Government directive
Risk Assessment (Outline any significant risks and associated mitigation)	Assessed within the Remobilisation Plan
Assessment of Impact on Stakeholder Experience	Assessed within the Remobilisation Plan
Equality Impact Assessment	No identified implications, and not required
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	No 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
CARSTAIRS, LANARK

COVID-19 REMOBILISATION PLAN
SEPTEMBER 20 - MARCH 21

GARY JENKINS: CHIEF EXECUTIVE

TABLE OF CONTENTS

1. INTRODUCTION

This plan describes the way in which The State Hospitals Board for Scotland (TSH) is approaching remobilisation for the period August 2020 to March 2021. 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'.

The plan incorporates service provision from the high secure estate at Carstairs, linkage with associated partnership agencies and stakeholders.

However, unlike many NHS Boards and healthcare providers, the core clinical function of TSH 'providing high secure care and treatment' has remained unchanged throughout the covid-19 pandemic. Referral routes from the justiciary, prisons and other NHS providers have been maintained. The major change relates to how care and treatment is delivered, supported by a safe clinical environment, where infection prevention and control is central to all decision making.

The risk of covid-19 infection will remain for the foreseeable future and until such times as a vaccine is available. Adaptability and flexibility will continue across the organisation with a key focus on the ongoing infection risks. TSH will continue to prioritise preventing infection, to rapidly respond when infection does present, manage any active cases, and ensure the overall safety and wellbeing of staff, patients and visitors alike.

Unlike other patient facing NHS Boards, TSH does not have out-patient services, elective waiting lists or day-case services. The plan is therefore written to reflect the individual and unique nature of a high security mental healthcare provider.

2. ACHIEVING INTEGRATION ACROSS NHS SCOTLAND FORENSIC SERVICES

2.1) TSH is the national high security hospital for Scotland and Northern Ireland. The hospital has continued to provide specialist individualised assessment, treatment and care, in conditions of high security for male patients with major mental disorders and intellectual disabilities. The patients, because of their dangerous, violent or criminal propensities, cannot be cared for in any other setting. There are three other high security forensic mental health providers in the United Kingdom: Broadmoor, Rampton, and Ashworth, all of which are situated in England.

TSH has maintained its core function throughout the pandemic. Any patient who required admission for high security mental health care and treatment has been accepted and admitted.

2.1.1) TSH has strengthened relationships with other NHS Scotland Forensic Mental Health service providers. Throughout the covid-19 pandemic, high, medium, low and community services have engaged in regular ongoing dialogue through scheduled conference meetings. These conference meetings align forensic mental health services together with the Scottish Government Mental Health Directorate, The Forensic Network for Scotland, the Mental Welfare Commission for Scotland, The Ayr Clinic (private provider) and other low secure care providers. This mechanism has enabled integrative planning discussions, debate on common challenges, sharing of knowledge, and monitoring around the overall scale of patient flow challenges across the forensic estate. Collaboration with those partnership agencies has remained successful and positive.

2.1.2) In terms of collaborative working, a short life working group was led by representatives of TSH involving West, East and North Medium and Low Secure care providers. The work was sponsored by the Mental Health Directorate team. The primary aim of the SLWG was to consider the view that the flow of patients across the levels of security, and through to the community, had stagnated from April onwards due to covid-19 related circumstances.

A detailed analysis of all patients in the system and their expected pathways across the estate was undertaken. The aim of the analysis was to determine:

- The current occupancy and flow challenges across the NHS Estate (High, Medium and Low Secure)
- Barriers and opportunities and improve integrative working and resolve any immediate flow issues
- Possible 'system challenges' for patients in low security (awaiting community discharge or placements)
- Recommend any restart opportunities across the Forensic Estate
- Consider a common approach to testing within the Forensic Estate

A matrix of the overall bed status (table 1) was reviewed in the context of the points above. A 'Forensic Mental Health Estate Overview Report' was developed and presented in the last week of July. Several barriers and opportunities were noted across the estate overall.

The provision of common testing approach within the forensic estate was also reviewed. The outcome is detailed in section 5 of this plan.

Table 1

Forensic Estate Bed Position: 20th July 2020

	The State Hospital		Orchard Clinic		Rohallion	Rowanbank		National LD	
	Male MI	Male ID	Male	Female	Male	Male	Female	Male	Female
Bed Capacity	**108**	**12**	**33**	**7**	**30**	**56**	**6**	**8**	**4**
No. Beds In Use	103	11	36	2	18	49	5	7	1
No. Empty Beds	6 2 being used by ID	1 cannot use as at ID capacity	2	0	12	7	1	1	3
No. Available Beds	5	0	0	0	9	0	1	1	3
No. On Waiting List for Access to Service (include booked beds for Pts on waiting list)	1	0	10	0	3 but no scheduled transfers from outside Board at present	18	0	0	0
No. On Waiting List Currently Placed OOA	n/a	n/a	4	0	3	4	0	0	0
No. Beds Booked (if impacts on no. available beds)	1	0	2	0	3	7	0	0	0
No. admissions planned for coming week	1	0	0	0	2	0	0	0	0
No. Patients in Service on Transfer List for Lower Secure Settings (if higher security put in brackets)	22	0	7	0	5	10	0	2	0
No. admissions since last Friday?	0	0	0	0	0	1	0	0	0
No. of those admissions that were an emergency?	0	0	0	0	0	0	0	0	0
No. Patients at TSH under Exceptions Clause?	8	0	4	0	1	3	0	0	0
Any foreseen potential issues this week in terms of capacity (taking into account patient mix etc.)	At ID capacity altho referrals for ID still being accepted. Not accepting new exc. circumstances admissions due to limited bed availability.		Currently closed to Emergency admissions due to increased activity and staffing challenges. Booked beds awaiting transfers x2 from TSH when approval given.		Two rooms in Vaara will be required for use due to clinical needs of new admission	No male acute beds. Planned transfers between sites being re-instated along with COVID guidance.			

2.1.3) Relevant to TSH, it was recognised that *'if all theoretical moves were possible (across all levels of security) there should be adequate capacity within High Security at The State Hospital. This is essentially the same position that existed pre covid-19, albeit the bottlenecks are significantly greater as a result of minimal patient transfers out from The State Hospital and across other services. Of note, there are 22 patients on the transfer list.'* These patients could be transferred if beds were available in other services.

2.1.4) To address the wider challenge, the following defined issues are actively being progressed through a national collaborative short life working group:

- Admission to secure mental health services
- Transfer between hospitals and services and levels of security
- Suspension of detention processes
- Preparation for, and moving into the community

The SLWG commenced in August and enables wider system common approaches over the next three month period to resolve the transfer and flow challenges. Of note, the work will focus on the covid-19 associated issues and will not cross-cut the ongoing work of the Independent Review of Forensic Mental Health Services.

2.2) In relation to wider national processes, TSH remains aligned to:

- The Independent Review of Forensic Mental Health Services led by Mr Derek Barron. This work was paused on 23 March due to the onset of covid-19. Correspondence has been received indicating that a virtual meeting will take place on 26 August to reflect and consider the next steps. Future dates for tentative meetings have been indicated. It is likely that a date for publication of the final report will be announced in October following discussion with Scottish Ministers. TSH will participate with this process and proactively work with the review team in the restart process.

- An interim report from the Scottish Mental Health Law Review was published in May 2020. This review is led by Mr John Scott QC. TSH has representation on the review process. The principle aim of the review is to *'improve the rights and protections of persons who may be subject to the existing provisions of mental health, incapacity, or adult support and protection legislation as a consequence of having a mental disorder, and remove barriers to those caring for their health and welfare.'* Due to covid-19, much of the review has been undertaken virtually. It is noted that a further interim report will be published around December 2020. TSH will participate accordingly with the various phases of the review process.

- TSH will participate as the NHS representative in the 'Custody Court Short Life Delivery Group'. This process has been established in relation to the creation of virtual court appearances.

- The Forensic Mental Health Network (hosted by TSH) assess transfer issues from prison in the forensic estates. TSH continues to work alongside the Network to ensure there are no excessive waits for prison transfer.

The above represents the key national linkage and integration processes for TSH in the context of the next three to six months.

3. COVID-19: THE STATE HOSPITAL ADAPTING TO CREATE A SAFE AND EFFECTIVE ENVIRONMENT

3.1) TSH has continued to manage service delivery through a command structure. The command structure was established on 16 March in response to the onset of the global pandemic and NHS Scotland moving on to an emergency footing. There have been modifications to the schedule of meetings based on the urgency and immediacy of matters presenting.

The organisation remains aligned to the direction of NHS Scotland. Each of the corporate directors and CEO are represented on the key national interface groups; this will continue going forward. Those linkages are described in appendix 1 of this plan, appendix 2 details the command levels.

3.2) As NHS Scotland moves through phase 3 of the Scottish Government routemap and into phase 4, along with the future removal of the emergency footing status for NHS Scotland, TSH will transition the command structure across to the following mirrored alignment:

Command Structure	Post Command Structure (to March 21)
Gold	Corporate Management Team
Silver	Organisational Management Team
Bronze	Hospital Management Team

The revised structure will enable refreshed decision making authority within each of the organisation. The model will adopt the lessons learned from the command structure debrief event held on 07 August. The construct of the revision also recognises staff feedback. This is specifically where innovation is noted around decision making, pace of change and the effectiveness of the leadership and managerial structures.

3.2.1) Minor re-alignment is planned within some Directorate portfolios. This takes account of new synergies and the beneficial aspects of inter departmental collaboration during covid-19. This too was reported in the staff feedback.

3.3) Work will progress with internal audit to determine how the audit programme for the remainder of 20/21 can be modified in light of the challenges presented by the onset of covid-19. Much of the audit plan was developed to take account of the transition to new Clinical Model at TSH. This Clinical Model implementation was scheduled to occur in June 2020 but has been postponed at this stage. TSH will restart the Clinical Model work in December with a view to implementation in 2021.

Work with audit partners will progress in August. This is necessary to assess how TSH best provide assurance and objectivity on the organisation's evolving structure and revised service delivery approach. This may provide further opportunity to assure the Board that the appropriate governance metrics are being measured, reported and adjusted in line with best practice and national guidance.

A draft revision of the audit programme will be developed by the end of September and presented to the Audit Committee and Board Meeting held in October for discussion.

3.4) A Scientific Technical Advisory Group (STAG) was introduced at TSH to meet the requirement from the Chief Medical Officer to ensure enhanced surveillance and appropriate review of epidemiological data. STAG includes public health, occupational health and infection control colleagues. STAG meets weekly and reports to Gold Command. STAG review proposals to guide the current interim clinical operational model, assess relevant literature and public health guidance, monitor the enhanced surveillance report, and consider national and regional modelling data.

The process has ensured that emerging evidence, guidance and national policy influence and inform decision making across the organisation. STAG has been an invaluable asset in advising the command structure on service modifications, assessing the risk of day to day patient activities, and providing overarching guidance to enable remobilisation.

In light of the ongoing threat posed by covid-19, second wave predictions from the modelling data - in addition to the additional challenges of enhanced seasonal flu vaccinations and other winter respiratory illness, STAG will remain in place for the foreseeable future to guide decision making. This will ensure that TSH is supported by multi professional representatives, including public health, in creating the safest possible environment and conditions for staff, patients, volunteers and visitors.

3.5) TSH Gold Command agreed the move to an Interim Clinical Operational Policy (ICOP). Two key 'milestone' measures were introduced to control the spread of infection. Following guidance from the United Kingdom and Scottish Government on 16 March, the organisation introduced a number of restrictions and social distancing measures, including:

- Staggering the use of dayroom and dining facilities
- Phasing the timings of patients utilising communal areas
- Staff guidance on the management of patients, the use of PPE, and infection control
- Closure of the Skye Centre from 21st March
- Closure to all family, carer and professional visitors from 21st March

The initial measures were based on the principles of each ward being a 'family unit' of 12 patients.

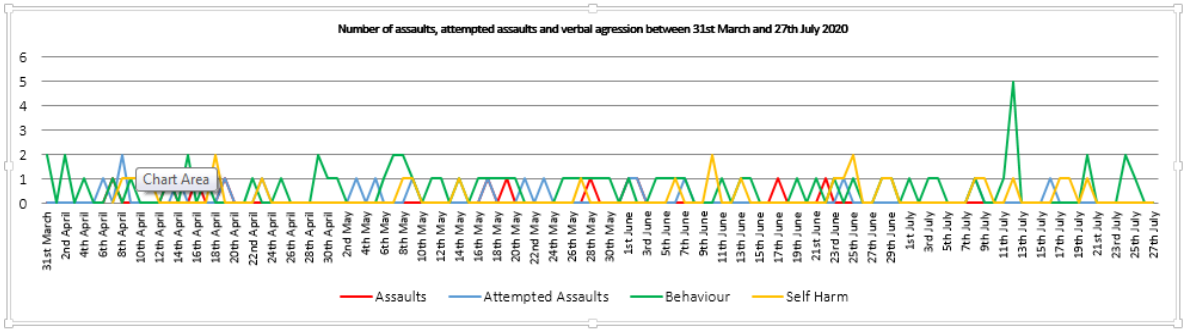
3.6) ICOP was introduced on 30th March, with a commitment to regular review and adaptations.

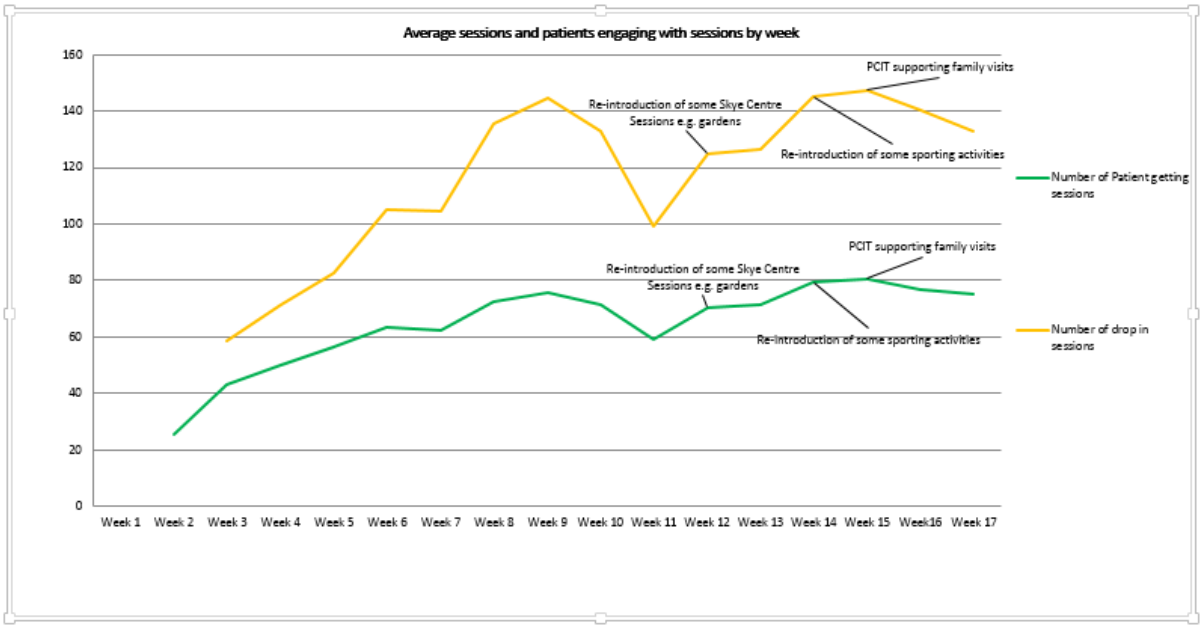
ICOP ensures safe care to patients through a social distancing model that minimises the risk of covid-19 transmission and protects patients and staff. In this model patients spend more time in their bedrooms. This is not seclusion, but is a variation of the model of confinement which is a well-established part of safe care delivery overnight. Each patient has an individualised care plan in place which specifically covers how their care needs are met during this period of physically distant interventions.

The impact on the patients' physical and mental wellbeing is measured daily. A weekly summary report is produced which monitors a range of indicators, some of which are unique to forensic mental health. They include:

- Assaults / Attempted Assaults / Aggression / Self Harm
- Complaints and Feedback
- Staffing shortages
- Enhanced observations
- Increases in DASA (Dynamic Assessment of Situation Awareness)
- Number of seclusions
- Incidents
- Patients unable to tolerate isolation
- Use of mechanical restraints
- Access to physical activity, Fresh Air and Walks
- Activity drop in interventions

The data is used to inform the direction of the ICOP through weekly monitoring processes and multi professional review. Extracts of data are demonstrated as follows:





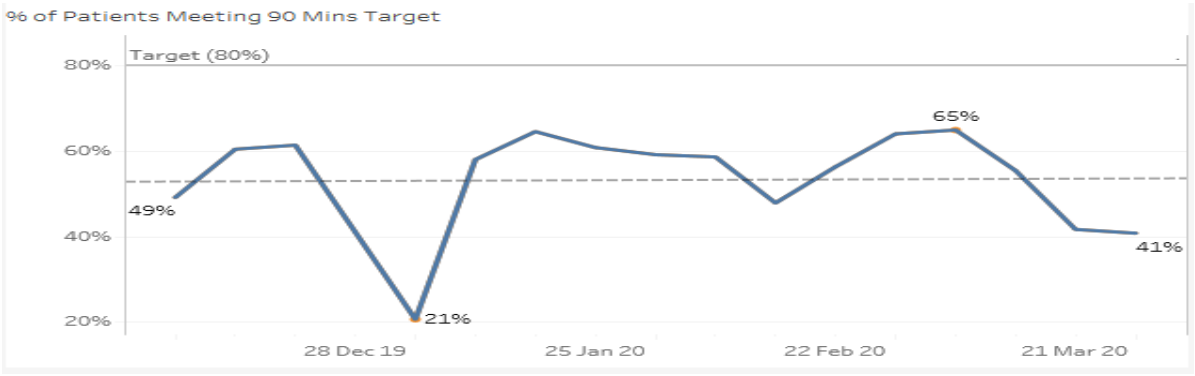
3.6.1) The ICOP oversight group is co-chaired by the Medical Director and Nurse Director. The review process involves various professional leads. Modifications to clinical care and treatment are recommended based on the indicator data and outcomes. The data is shared with a wider range of multi-disciplinary clinical team with actions taken to ensure quality of care and protection of patients is maintained. TSH is currently operating on version 11 of the ICOP.

3.6.2) Updates are shared with the Mental Welfare Commission for Scotland for transparency and review on a weekly basis. The full range of activities currently available to patients under the ICOP is detailed in appendix 3. The Mental Welfare Commission for Scotland are visiting TSH on 18 August and feedback or planning amendments will be incorporated thereafter.

3.6.3) There have been some early outcome data showing positive impacts from the ICOP introduction. An example of this is patient physical activity levels pre and post ICOP.

Pre ICOP data has been collected from the 01 December 2019 to 29 March 2020 using data recorded on Rio (patients record system). From this timeframe an average of 53% of patients overall participated in 90 minutes moderate physical activity. The data shows that 65% was the highest percentage of patients meeting the target of 90 minutes moderate physical activity over the course of a week. This did not meet the target set by the organisation of 80%. Additionally, on average 16.8 patients were recorded as having no physical activity interventions.

Chart 1: Pre ICOP



Data has been collected from 30 March 2020 to the 21 June 2020.

Chart 2: With ICOP

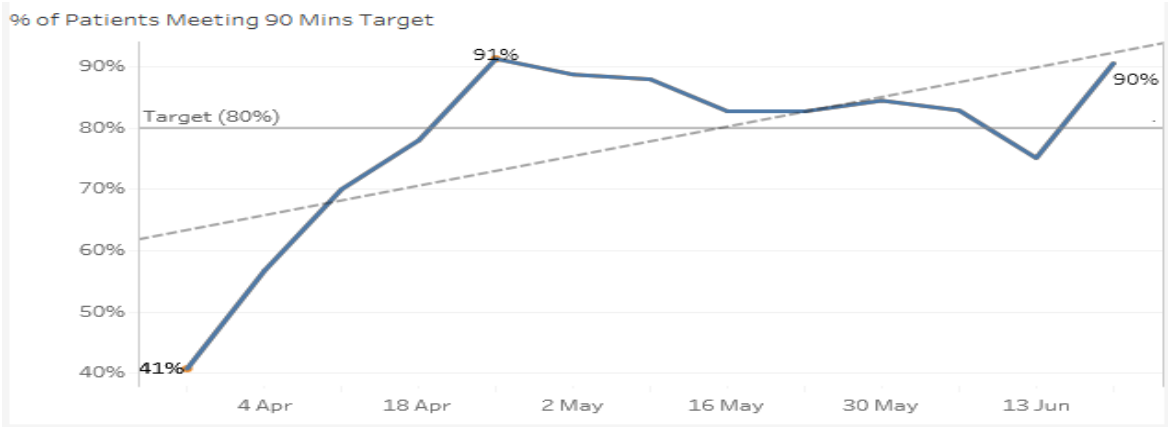


Chart 2 shows the percentage of patients who met the target of participating in 90 minutes moderate physical activity from the 30th March to 21st June 2020. The data demonstrates that from mid-April 80% of patients have been participating in 90 minutes moderate physical activity. This has been maintained until just recently, when there was a slight decrease due to poor weather. This has continued to improve. Since ICOP was introduced, the average number of patients with no physical activity has also decreased from 16.8 (pre ICOP) to 6.9 during the ICOP period.

3.6.4) This outcome may not seem remarkable in itself, however a recent article published in the British Journal of Psychiatry 'Morbidity, suicide, and all-case mortality in a Scottish Forensic Cohort over 20 years' highlights the essential need for physical exercise within this specific patient cohort. Appendix 4 provides a reference to the article.

3.6.5) The necessity for a comprehensive holistic approach to individual patient physical and mental health needs and longer term outcomes is a vital component of care and treatment planning. This is particularly

relevant given the average length of stay is circa 6 years (range: 3 months - 34 years) based on the current patient cohort in TSH.

The ICOP will remain in place throughout phase 3 of the routemap. An analysis of the positive and negative outcomes is underway and will inform the service delivery model in phase 4 and beyond. This will include a dissaggregation of patients with major mental illness and patients with intellectual disabilities; the needs of both vary significantly.

4. COVID-19: INFECTION CONTROL AND REDUCING THE RISK OF NOSOCOMIAL INFECTION AT TSH

4.1) As requested in the letter to NHS Boards on remobilisation planning, TSH has outlined a number of additional measures to reduce the risk of nosocomial infection in the State Hospital. For assurance purposes these are:

- All staff are wearing face masks when they are in ward areas and undertaking dedicated patient activity. An 'all staff communications briefing' of FAQs has been developed and circulated and adhered to.

- Housekeeping staff have increased their frequency for decontamination of frequently touched surfaces to twice daily this is reflected in the amended cleaning schedule as per HFS National Cleaning Specification, including the Facilities Monitoring Tool. Supplementary to this nursing staff are required to decontaminate frequently touched surfaces once per shift. Decontamination is undertaken with a chlorine based product (1000ppm). There are no issues relating to stock supplies of products at present. Communication has been issued via staff bulletins advising staff on how to use the products correctly and all safety data sheet & COSHH documents are located on the intranet.

- The Estate and Facilities Directorate have a water safety recording system whereby water outlets are flushed as per SHTM guidance, there has been no change to current practice.

- All staff are required to maintain physical distancing as they enter the site. Markings are in place at reception.

  Staff can only enter the 'tube-style entry' into the secure x-ray, scanning and search area once the zone is clear of other staff members. The search process has been modified to enable security staff to wear PPE for any physical searches. Hand held metal detectors have been introduced to avoid the need for physical contact as far as possible.

  The number of staff entering the 'key safe & attack alarm area' has been reduced to a maximum of three at any one time.

- The covid support team have reviewed floor plans and identified maximum room occupancy both for patient and non-patient areas including office accommodation. An overall accommodation schedule has been developed to enable physically distanced working practices.

- Nursing staff have developed a system which supports minimal congestion in ward and clinical areas.

- TSH staff have been supported to be flexible in the start and finish times.

- Areas and departments which may be unable to maintain 2m physical distancing consistently (such as catering and procurement) have infection control risk assessments in place which supports the extended use of face masks.

- Staff are rostered a base ward and will only be relocated if resource issues dictate. A register of staff movement is maintained by the covid-19 action team. The process of managing soiled uniforms is managed as per Safe Management of Linen policy. Staff have access to shower facilities. Staff have been provided with advice on home laundering of uniforms this is consistent with previous practice.

- The existing ward environment supports the segregation of suspected and confirmed cases. New admissions to the Hospital are tested on arrival, and remain in isolation until the test results are received. All wards at TSH are single room with ensuite.

- The internal grounds have been marked up so that patient movements flow in a one way system. Patients are observed at all times whilst on grounds access by the security control centre through CCTV. If patients fail to adhere to physical distancing, ground access can be removed or restricted.

- All staff who are able to work remotely or flexibly have been given approval to do so. This model also reduces the flow of staff through the hospital site and minimises bottlenecks at the key security check points on entry and egress of the campus. Where physical cover is necessary, line managers have been encouraged to think differently about the deployment of staff to restrict contacts with others.

- TSH has implemented all relevant guidance associated with the use of PPE. There have been no supplies challenges to date with receipt of these items. The Resilience Lead participates in the national calls and is the single point of contact for TSH supplies related issues.

- All nursing staff have been fitted for FFP3 masks; face fit testing was undertaken on site. The use of FFP3 is limited to emergency procedures such as cardiac arrest. However it is recognised that if a patient is required to transfer off site and potentially into critical care, TSH staff must remain in attendance with the patient due to the severity of risk and harm posed by the patient. That may necessitate the use of FFP3 masks.

- Through liaison with National Services Scotland, there is no perceived risk to the supply chain for TSH. Additionally, it is unlikely that demand will increase substantially as TSH progresses with remobilisation.

4.2) A strong focus on infection prevention and control has been central to the response. The Senior Nurse for Infection Control is part of the internal covid-19 action team; external support is provided from the Infection Control Doctor in NHS Lanarkshire.

National guidance related to covid-19 is being issued regularly and is also subject to regular and ongoing updates. To help ensure connectivity in this area the Senior Nurse for Infection Control is involved in the following teleconferences:

- Health Protection Scotland
- The State Hospital medical staff daily
- The State Hospital staff side daily
- Silver Command briefings

4.2.1) All changes to clinical practice and service delivery are reviewed and endorsed through the infection control route and STAG prior to implementation or practice change. TSH has approved additional funding to enhance infection control and public health support. The costs are identified in the financial section of this plan.

Guidance is being tracked and reviewed on a daily basis to ensure that TSH is operating in compliance with all relevant guidance. The covid-19 action team is tracking each guidance document as they are received and disseminated across the organisation. This will continue into the winter months.

4.3) All of the above measures will continue over the coming months with appropriate modifications based on emerging national guidance associated with routemap phases.

5. Testing of Healthcare Workers and Patients: The State Hospital and Forensic Estate

5.1) Following the inception of the debate on testing within the forensic estate, there has been considerable new information published. The latest information clarifies the majority of the core questions and supersedes some of the initial concerns over the interpretation testing guidance.

5.1.2) Ms Haughey, Minister for Mental Health, wrote to Chief Executives and Board Chairs in relation to the testing process for new admissions. The letter, issued on 26 June, 'Covid-19: Pre Testing of New Admissions to the Secure Estate', cites the following:

- All admissions to secure mental health in-patient services be tested for covid-19. This includes transfers between secure mental health hospitals.
- The presumption should be that all patients being admitted to a secure hospital should have a negative test before admission, unless the patient does not consent to a test, lack the capacity to consent or it is in the clinical interests of the person to be moved urgently and then only after a full risk assessment.
- Testing should be accommodated within existing testing programmes, given the limited number of admissions and transfers.
- We are working with forensic service health practitioners who are developing proposals to promote a consistent approach to infection control in secure mental health services and we expect those proposals to be shared with NHS Chief Executives in the near future.

5.1.3) Ms Tracy Slater, Interim Deputy Director issued further guidance. The letter, issued on 03 July, 'Guidance – Testing Healthcare workers' identified a testing programme for staff in long-stay mental health where the length of stay exceeds three months. The operational definitions associated with the letter did not specify the Forensic Estate although did state the L.D. population. Further clarification was received from Ms Slater on 23 July as cited below:

'We have also been asked to provide further clarity on some eligible staff. To confirm Paediatric Cancer services are within the scope of this testing cohort while Forensic Psychiatry and rehabilitation services not for older adults are currently not within the scope of this cohort.'

5.1.4) As guidance, and covid-19 infection rates change, it may be the case that the above criteria will be revised. However at this point the guidance stipulates that Forensic Mental Health is not within the scope. TSH is compliant with the national guidance cited above.

5.1.5) As a further measure to support the letter from Ms Haughey of 26 June. Infection Control and Prevention advice was sought; colleagues agreed that the following recommendation would be reasonable for TSH to adopt:

- All patients for transfer or admission are tested 48 hours in advance
- If a patient is presenting with symptoms then delay the transfer
- If a patient presents with symptoms and tests positive – delay transfer until 7 days post positive result plus 48 hours apyrexial without the use of paracetamol
- If the patient is asymptomatic but returns with a positive test – delay the transfer for 7 days
- If a negative result is received and the patient is asymptomatic – transfer as normal

5.1.6) Within TSH, the following approach remains the extant position for staff testing:

- Testing will be undertaken on the grounds of symptomatic presentation, or if a member of staff has an immediate household member self-isolating due to symptomatic presentation.

- In the event of an outbreak of an infection in one or more areas, TSH will move to testing of all staff and patients at regular intervals, similar to the current process for priority 1 care homes. Oversight for this process will be led by Infection Control and Public Health colleagues through the initiation of a Problem Assessment Group (PAG)

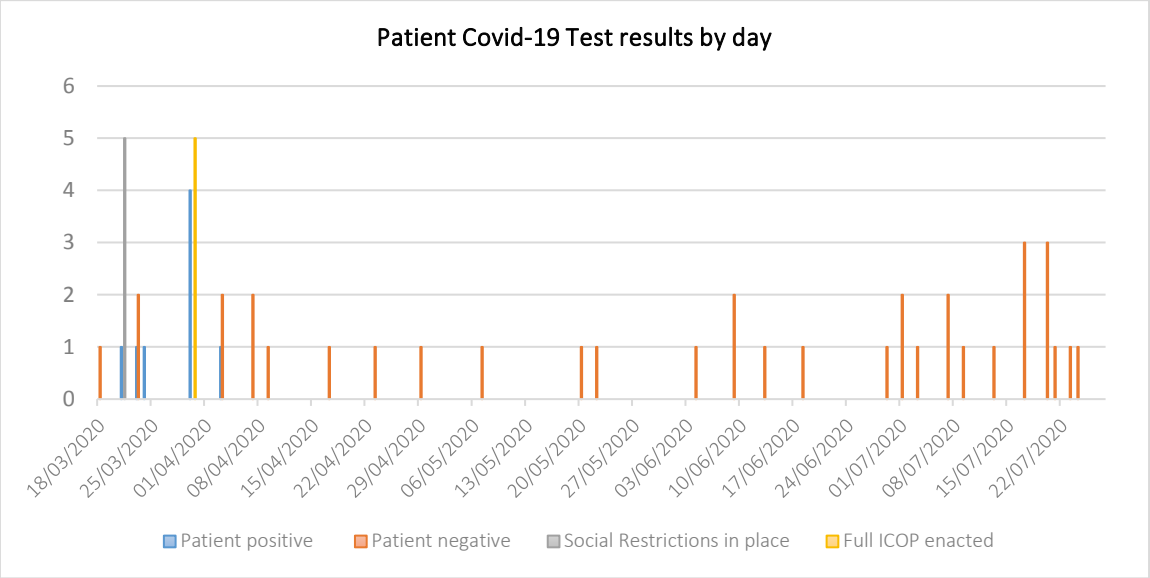
- Testing kits for TSH will be issued via central supplies at Hairmyres Hospital. The kit will be delivered and collected via a volunteer driver service. The testing will be performed at Monklands Hospital laboratories. Staff information has been provided for uploading of individual CHI information.

5.1.7) The process for staff and patient testing will remain under continuous review and based on emerging knowledge and testing developments. Adaptations will be introduced aligned to national guidance and direction.

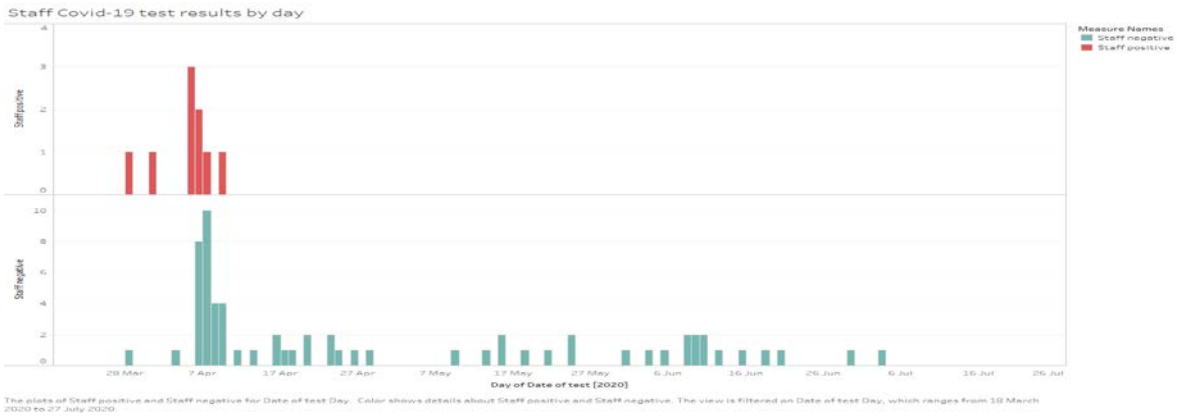
5.1.8) TSH have developed an internal tracing system with support from Infection Control and Public Health. This enables patient to patient, and staff contacts to be identified and mirrors the national tracing approach. The approach was taken due to the unique environment within TSH. The covid-19 action team have undertaken a test of the tracing system based on a hypothetical infection outbreak.

6. COVID-19: THE STATE HOSPITAL - PATIENTS & STAFF

6.1) There has been a total of 8 confirmed cases of covid-19 within the patient population at TSH. The first infection was detected at the end of March 20 with cases rising to a total of 8 by the first week in April 20.



6.2) Of all TSH staff (n=650), 72 staff have been tested to date. 9 staff have tested positive for Covid-19, with 63 testing negative. This represents the period up to 27 July 2020. The data in the graphs below demonstrate that the timeframe of positive staff tests is broadly consistent with the onset of patient infections.



6.3) The majority of staff tests have been conducted within the Nursing directorate. This includes Clinical Administration staff, Allied Health Professionals and Skye Centre staff. A number of tests have also been conducted on the Security, Estates and Facilities staff directorate, with very small numbers of tests conducted on Medical, Psychology, Forensic Network and other staff groups.

7. Maintaining Covid-19 Capacity

7.1) At the onset of the pandemic, TSH created a six bed General Medical ward equipped with oxygen and supplies. The ward is ready to accept any patient who requires enhanced care for symptoms of covid-19. Additional and refresher training has been provided to staff.

7.2) Covid-19 Clinical Care Support Documentation has been developed to assist in the care of patients who develop covid-19 within TSH. The documentation was developed in partnership by individuals within TSH and NHS Lanarkshire. TSH will provide support to patients who require enhanced medical and nursing care on site for physical health symptoms as a result of covid-19. Patients with significant comorbidities have been identified.

7.3) All patients have been reviewed in relation to their risk factors should they require transfer off site for enhanced care. Individual transfer plans include the number of escorting staff required to manage the patient. This includes an assessment of the use of handcuffs and other risk factors including government and Police Scotland notification. This document is active and can be used to enable a rapid transfer should there be a deterioration in an individual's health. A contact point with the A&E team in NHS Lanarkshire is in place to allow direct access in the event of a deterioration or medical support and transfer.

7.4) Near-me technology was introduced at the on-site health centre at TSH. This technology enables the General Practitioner to undertake remote consultations and avoid attending the site unless absolutely necessary. The model works well and will remain in place going forward.

7.5) Pharmacy supplies are provided to TSH by NHS Lothian. There is no anticipated supply issues affecting clinical care provision. There are no foreseeable changes to pharmacy demand associated with remobilisation or Brexit.

As part of preparedness for the predicated second wave, and wider winter respiratory illness, the above measures will be maintained for the foreseeable future with review at two monthly intervals. No patient has yet required transfer off site due to covid-19 related issues.

8. Virtual and In Person Visiting

8.1) Video conference facilities were introduced in April to all hubs enabling virtual visits between patients, families and carers. This is a completely new service for patients in high security care. Uptake is as follows:

	Arran		Iona			Lewis			Mull		Total
	1	2	1	2	3	1	2	3	1	2	
Number of calls	18	31	11	68	27	27	16	17	5	10	230
Number of patients	7	4	8	5	8	7	4	5	3	5	56
Usage – family	15	31	7	67	27	15	15	16	5	6	204
Usage – profess'l adviser	-	-	2	1	-	7	-	-	-	1	11
Usage – clinical	3	-	2	-	-	5	1	1	-	1	13
Usage – interpreter	-	-	-	-	-	-	-	-	-	2	2

Whilst a small number of calls have failed due to issues at the recipient (e.g. their firewall, out of date internet browsers), ward staff and social work are being very supportive with families in helping to set things up where they can assist. Additionally, a few patients have expressed a preference for telephone calls but all patients

are being encouraged regarding the facility and are being made aware of what is available. The model has been security assessed to ensure compliance with legal restriction orders.

8.2) Legal representatives are also offered access to the facility to avoid the need for unnecessary travel to Carstairs. One case has been made to the crown to assess if this model oppresses the rights of the patient and legal representative. An outcome is awaited and practice will be amended accordingly.

8.3) In person site visits recommenced week beginning 13 July. This is for a single named visiting contact in line with national guidance. The family centre has been re-designated as a suitable area for in-person visits. This is to avoid the need for visitors to travel through the hospital site and onto actual wards. Physical distancing and spacing was agreed and implemented in line with infection control guidance.

The following table details the number of visits that occurred in week 3:

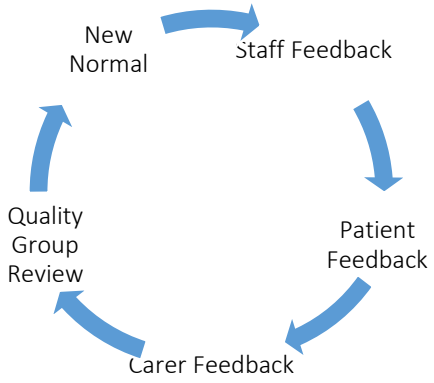
Number of patients who have approved visitors	93
Visit capacity	48
Number of visits to be scheduled	20
Number of visitors requesting a weekend visit and unable to visit Mon-Fri	0
Number of actual visits	17

Virtual visiting will be maintained for a further six months. This has the added benefit of allowing relatives, careers and volunteers to see patients without the need for travel. This may be of particular benefit for individuals travelling significant distances across Scotland and Northern Ireland. A review of the facilities and its continued use will occur with further easing of visiting restriction.

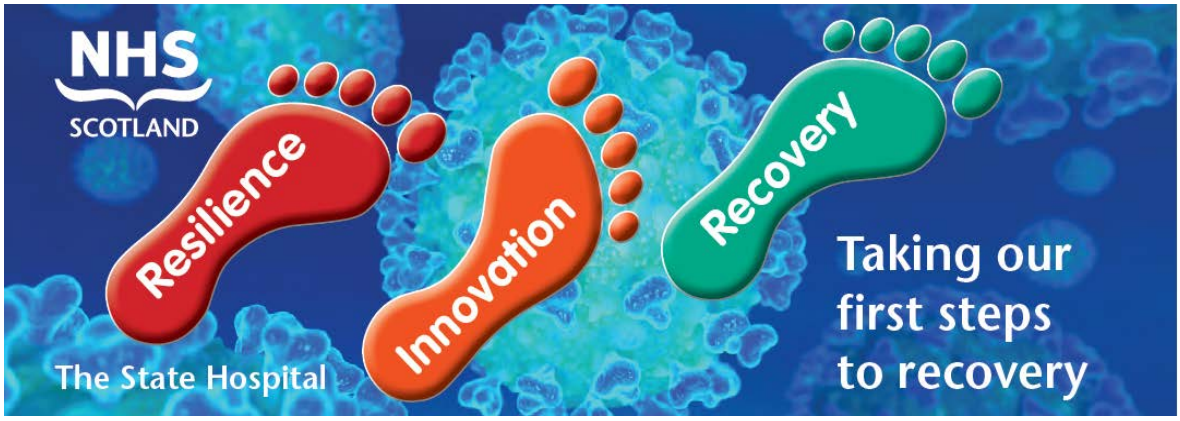
9. Learning from Feedback: Staff, Patients, Carers and Volunteers

9.1) The pace at which change has occurred is testimony to the singular focus of the organisation in supporting fellow staff, patients and carers against the backdrop of the global pandemic. All staff have gone above and beyond to ensure that rapidly emerging guidance have been deployed into core operational practice as swiftly as possible. There is a need to ensure that the organisation builds on the positive aspect of change by considering which forms of practice worked for staff, patients and carers.

9.2) In order to establish the impact of change, both positively and negatively, TSH initiated a 3-tier feedback and engagement processes:



9.2.1) A series of engagement activities have taken place across TSH. This is to support recovery and renewal planning and engage staff learning to inform future plans. Patient, carer and volunteer feedback has also been sought through this approach.



9.2.2) The staff engagement activity proved an opportunity to 'check in' with staff and understand their experience of the recent changes. Staff engagement processes targeted specific groups such as RMO's and clinical leaders in addition to all staff from all levels and departments across the organisation. Over 250 staff members engaged in responding to questionnaire, teleconference calls, MS team meetings, 1:1 discussions and group response activities.

The staff survey provided feedback on the following:

- What is going well and why?
- What new practice would you want to embed in future working?
- What would we need to change or amend as we continue in the current situation?

9.2.3) Building on themes raised, a series of 13 conference linked discussions, each led by the Chief Executive, took place throughout May and June 2020. The main themes from the staff survey were used as a baseline for discussion. The participants were asked to feedback what was important to them moving forward, what they would want to build on and embed in future work and what they would not wish to see a return to.

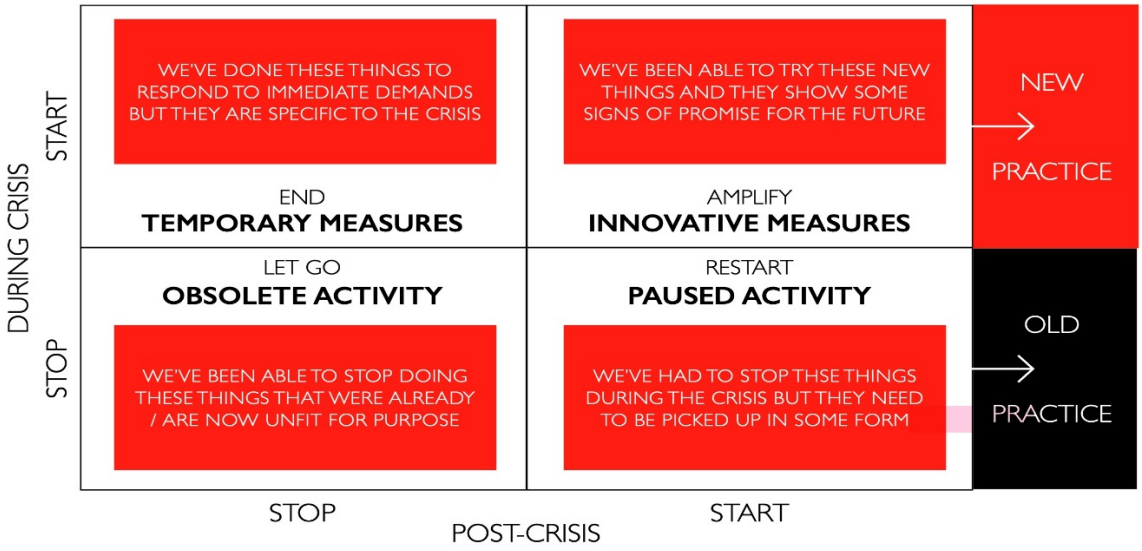
9.2.4) Members of the Quality Forum engaged in these discussions to reflect a QI approach to planning for recovery. Staff side were also engaged in the discussions to ensure a partnership approach. A Staff Bulletin was developed and published in June to share the feedback activities, with local posters displayed in staff areas to feedback the key areas raised.

9.2.5) Through the engagement activity, a range of common themed issues emerged. These are listed below:

- Staff Health and Wellbeing
- Digital transformation
- Building a personalised approach to care
- Increase in patient activity and improve physical health of patients
- Organisational and clinical effectiveness and reduction/ review of low value activities
- Organisational leadership and culture

9.2.6) Further engagement was carried out across July. The Royal Society for Arts template was used to support organisational learning from covid-19. The model informed strategic planning through the assessment of temporary, innovative, paused and obsolete activity.

9.2.7) The staff engagement exercise has been positively received. Many respondents identifying areas of creative and innovative practice as a result of changes to care and service delivery. The opportunity to change aspects of how the organisation delivers care in the future were identified. An overall impression that staff were keen to pursue a process of change was apparent. The matrix below provides a high level summary of the key areas raised in the RSA framework.



Establishment of IC structure. Establishment of Covid-19 support team. Establishment of Clinical Operation Guidance and Monitoring of this. Establishment of STAG. Home/remote working. Business meetings held through MS Teams. Changes to practice: taking an infection control and PH approach (security, estates and facilities, site cleaning). Suspension of training activities including H&S. Establishment of Medical Ward i.e. Mull 3 ward for Covid-19. Redistribution and changes to staff roles and activities in response to Covid-19 restrictions to continue to provide patient-centred care. Improved collaborative working to facilitate patient-centred care. **TEMPORARY ACTIVITY**	Changes to clinical team meetings and practices to be more tailored to needs of patients. Increased access to outdoor activities and fresh air for patients. Clinical teams given autonomy to adapt ICP's. Flexible and efficient approach to meetings which stand up meetings quickly as required. Increased use of digital technology to enable attendance at meetings. Home and remote working success – blended approach. Development of systems and processes to be more efficient and responsive to need. Greater connection to external partners (NSS, NHS Lanarkshire). Staff wellbeing approaches should continue to evolve to support staff based on need. Streamlined decision making. Revised leadership and management structure. Shared sense of purpose. Continue to increase physical activity for patients. Continue to evolve use of data for assurance and improvement. Grounds access policy. Pace of change. **INNOVATIVE ACTIVITY**	**NEW PRACTICE**
Review meeting structure and function to ensure current and responsive to need. Ensure that systems and processes make best use of staff time and provide quality impact for patients. Gathering of data and reporting that does not drive improvement. Travelling to national meetings. **OBSOLETE ACTIVITY**	Clinical model. Strategic review of performance. Training – H&S, PMVA, PTS. Monthly PPG Meetings. Management meetings – managerial decision-making. Supporting healthy choices. Implementation of HEPMA. **PAUSED ACTIVITY**	**OLD PRACTICE**

9.3) Feedback has been considered by the Recovery and Innovation Group, Gold Command and the QI Forum. Change concepts are currently being aligned with quality improvement measurements and will drive a change model. A programme of work is actively underway to coordinate the delivery timeline over the next three month period. This is a live and active exercise. A full programme will be in place by September 2020.

10. Staff Wellbeing & Human Resources

10.1) Ms Clare Haughey, Minister for Mental Health, wrote to all NHS Scotland employers on 26 March 2020 stressing the need to ensure that local arrangements are in place for the provision of mental health and wellbeing support for staff during covid-19. NHS Boards were asked to identify a local champion for staff wellbeing and further guidance, outlining essential support arrangements required within each NHS Board, was issued by the Scottish Government on 14 April 2020. This was set out in DL (2020)8 - Staff Wellbeing and Support: Employers' Duty of Care During covid-19 Pandemic.

All NHS Boards have been urged to take a proactive approach and to work in partnership with staff side colleagues, health and safety leads, public health, occupational health, and other relevant services to support employee health and wellbeing throughout the pandemic.

10.1.2) Within TSH, the Professional Nurse Advisor is the nominated Wellbeing Champion and is co-ordinating the local response. A Workforce Wellbeing Group has been established to assist in identifying and addressing local needs and 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 being sought as and when required.

A tiered support model has been adopted locally, based on the principles of Psychological First Aid (i.e. Care, Protect, Comfort, Support, Provide, Connect, Educate). 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.

10.2) A review of local arrangements for staff wellbeing and support was undertaken in April 2020 to assess compliance with the guidance provided in DL (2020)8 - Staff Wellbeing and Support: Employers' Duty of Care During covid-19 pandemic. A wide range of interventions are in place. Other key initiatives are highlighted below.

10.3) A designated staff wellbeing zone was launched on 6 May 2020. This is located onsite within Islay and aims to provide a space for staff to relax and recuperate away from their work environment, and to make it as easy as possible for individuals to access the support they need. The wellbeing zone is open to all staff and includes:

- Provision of information that addresses the wide range of challenges staff are facing during Covid-19. This includes information on:
  - Staying safe and well
  - Emotional wellbeing
  - Importance of sleep and rest
  - Social connections and managing loneliness and isolation
  - Eating well and up to date information on supermarket opening times for NHS staff
  - Physical activity and how to stay active
  - Resilience and managing stress and anxiety
  - Home working
  - Financial support and advice and how to access local food banks
- Information on factors that can affect emotional and psychological wellbeing and guidance on how to recognise and respond to personal "warning signs".
- Signposting to self-care resources and to the help and support that is available nationally, locally and within the organisation.
- Access to online resources, peer support, refreshments, and a quiet space to relax and reflect.

In addition to the above, the Hospital has received donations of biscuits and cakes from local businesses to make available for staff within the wellbeing zone.

Volunteers, from across all disciplines, were invited to give some of their time to be present within Islay to provide peer support to staff, if required, and to make them feel welcome in the wellbeing zone. The response to the request has been very positive. TSH have been able to ensure that a volunteer is present within the wellbeing zone every day to provide peer support.

Initial feedback from staff is that the zone is a welcoming space with an abundance of useful information. Staff have enjoyed the opportunity to have a drink, a biscuit and a chat with the volunteers. Volunteers have reported that they have also benefitted from having interactions with a number of staff whom they would rarely come into contact with.

A virtual version of the wellbeing zone has been created on the learnPro platform to provide access to the information and resources currently located within Islay to staff that are shielding or working from home, or who are unable for other reasons to access Islay.

10.4) In addition to the local initiatives and interventions, a Wellbeing Champions Network and National Wellbeing Hub have been established by the Scottish Government to facilitate the sharing of resources and good practice, and to promote collaborative working across health and social care organisations within the public, private and voluntary sector. There are also plans to establish a national baseline assessment of wellbeing, and an agreed trajectory for improvement.

The National Wellbeing Hub is a new online platform that provides signposting to the wide range of support and wellbeing services and (self-care) 'tools' available across health and social care organisations in Scotland. The hub is being created and updated in partnership with Wellbeing Champions from across the health and social care sector in Scotland and had an initial 'soft launch' on Monday 11 May 2020.

10.5) TSH was recently successful in securing a funding grant of £35,000 from the NHS Charities Together Covid-19 Appeal. The funding grant can be utilised to support projects and equipment aimed at enhancing the well-being of staff, patients and volunteers affected by Covid-19. This might include for example:

- funding well-being packs for staff and volunteers on wards/departments - which could include food/meal deliveries and refreshments, wash kits, furniture for rest rooms
- supporting patients' mental health through isolation through the purchase of games, radios, or electronic communication devices so they can talk to family
- benevolence
- other items identified by staff, patients or volunteers

The above list is provided for example only and work is currently being progressed by the Wellbeing Champion to generate suggestions and ideas on what would be of help locally, and to establish a process and associated governance framework for managing the use and allocation of the funding grant.

10.6) Options for enhancing support to leaders and frontline managers are also being explored. Key priorities include provision of training on Psychological First Aid and coaching support for managers.

A national online coaching hub is being set up by NHS Education for Scotland to coordinate access to coaching support in partnership with external provider 'KnowYouMore'. The register will include coaches from the Executive Coaching Register as well as coaches from the Coaching Matters website. Funding is being provided by the Scottish Government, and coaching can be accessed by managers at all levels. A free 'Coaching for Wellbeing' support service is also being made available through Project Lift.

In summary, a wide range of initiatives and interventions are in place, or planned, to support staff health and wellbeing during the Covid-19 pandemic. A staff wellbeing survey is also being considered to assess the impact of the pandemic on staff health and wellbeing and to assist in evaluating the impact of the support measures that are put in place.

Workforce

10.7) The most valuable asset in The State Hospital is the 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.

10.8) The configuration of TSH workforce changed. In light of the pandemic colleagues redeploying from non-ward based roles to support the ICOP and the provision of covid-19 care, alongside a targeted recruitment exercise to increase our available nursing workforce.

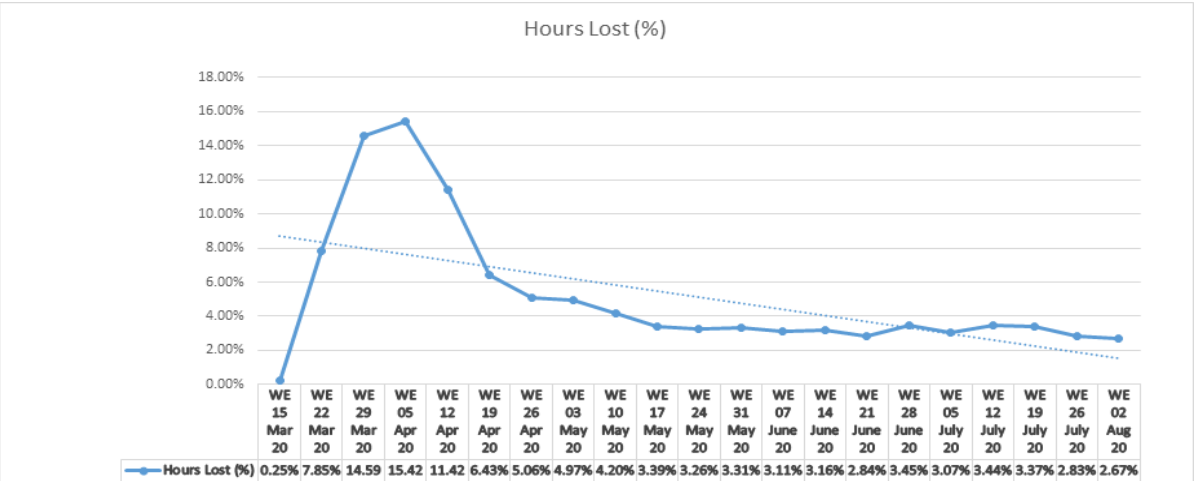
10.8.1) Whilst responding to the pandemic it became clear that a number of colleagues' roles had changed. They had developed new ways of working and different approaches to ensure person-centred care continued to be at the heart of all we do, whilst responding to the challenges with the Pandemic. Just one example of this was the revised roles undertaken by some rehabilitation staff where they undertook ward based roles in addition to their core role. This improved the patient experience, increased efficiency and supported ongoing physical health.

TSH has committed to ensuring positive examples of changes to practice or service delivery will become part of revised service delivery.

10.9) A number of supportive mechanisms have been introduced in the last twelve-month period tailored towards assisting individuals with workplace attendance. Support includes:

- Dedicated Occupational Health Service and Advice line; includes both formal and informal consultations and drop in "clinics"
- Counselling/talking therapy provider
- Specialist Psychology for those experiencing trauma.
- Access to workplace stress risk assessment tools & support
- Support on 1st day of absence via EASY (Early Support for You) on mental health issues, immediate opportunity to access clinical advice via OH
- Dedicated named case manager support for anyone with mental health issue.
- Assessment and action planning to resolve issues at both work & home.

10.10)In terms of absenteeism TSH is seeing a downward trend of Covid-19 related absence among our workforce from a peak in week commencing 6 April 2020 as illustrated below.



The covid-19 related work hours lost includes:

- staff self-isolating due to being symptomatic
- staff isolating due to a household member being symptomatic
- staff who were shielding due to being in a 'high risk' group, or being the main carer for a dependent in a 'high risk' group. Shielding is currently paused and these staff are currently being supported back to work in line with government guidelines.

In preparation for the pause in Shielding a manager and employee "Toolkit" was devised in consultation with staff and their representatives. This consultation included sharing initial draft documents with those who were shielding to start a positive dialogue with them and provide reassurance their employer was working within Government guidelines to provide them with a COVID secure workplace.

10.11) TSH has encouraged, where it is practical, colleagues to work from home, and have invested in laptops and related infrastructure to support this. It is recognised that a return to full-time office accommodation in the near-term is impractical and that home-working, for some roles, may be suitable in the longer term. A blended approach with a mix of working from home and on site is also being deployed. The emphasis is very much on supporting individuals to adapt to new ways of working whilst maintaining delivery of service. A review of space utilisation has been undertaken to compliment this important strand of planning for future working accommodation.

Flexible and remote working will continue to be encouraged and supported over the coming six months.

10.12) The Boards Annual Workforce Plan was presented to The Board in autumn 2019. The workforce numbers demonstrate the age distribution of staff. 93 staff are in the age range of 50- 54, with a further 46 staff in age range of 55+. This presents a risk to the workforce stability in the coming five-year period. In order to proactively manage this risk a number of positive steps have been enacted including;

- The development of a workforce and recruitment plan to describe key milestones, risks and mitigating actions.
- Engagement with our Health Care Support staff to provide a model of further education specifically leading to Registered Nurse training.
- A positive and pro-active Practice Development team leading innovative approaches to professional development.
- Active and ongoing participation in the NHS Scotland management training scheme.
- Support in the delivery of the NHS Professional Careers programme in partnership with Scottish Government and the Glasgow Centre for Inclusive Living.
- A commitment to extend the adoption of Modern Apprenticeships at every opportunity and across all disciplines.
- A comprehensive organisational training plan which includes statutory and mandatory components as well as a broad range of multi-level leadership development programmes.
- Participation in the national work stream Project Lift.

A key component of the workforce plan is the creation of further educational opportunities to develop staff from within the service and provide lifelong employment. This links to the programme for government and the renewal landscape by 'encouraging people to stay in Scotland and move within Scotland to address regional skills gaps'.

Health and Care (Staffing) (Scotland) Act 2019

10.13)TSH had been implementing the workforce tools associated with the Health and Care (Staffing) (Scotland) Act 2019 prior to the onset of covid-19.

The unique environment and patient group at The State Hospital can lead to challenges with ensuring that the correct distribution of staff are in place at the correct time. Fluctuations with clinical activity can require our patients to receive very intensive support from staff.

10.13.1) As part of the modelling exercise for the Clinical Model staffing profile, considerable work was undertaken to rebase the core establishment numbers. The modelling took into account the professional judgement aspect of the workforce tools, historic issues with base staff numbers per ward and assessed comparable high secure hospitals in NHS England.

10.13.2) Further work is ongoing and will be refined over the coming 12 to 24-month period to review the effectiveness of the staffing model and ensure that correct resources are deployed across the organisation. TSH will continue to work in collaboration with Healthcare Improvement Scotland and the Chief Nursing Officer for Scotland's team in reporting the outcome and opportunities associated with this legislation. The Board will also be briefed on any challenges or actions required to meet the requirements of the safe legislation going forward.

The outcome and action measures for The State Hospital, as described in the reporting framework are as follows:

Outcome 1 - Development and management of implementation of systems for the following actions:

- Ensure the common staffing method is embedded in practice. This will include development of and co-ordination of implementation of an annual plan to ensure all workload workforce tools are applied within nationally agreed timescales.
- Ensure a consistent approach to analysis of workload and workforce information, quality measures and local contact to inform staffing requirement across the NHS Board.
- Ensure a consistent approach to risk identification, escalation and prioritisation on a Board wide basis.
- Ensure a consistent approach to seeking and having regard to clinical advice in relation to staffing.
- Utilise data to identify service redesign and role development opportunities and to predict future service and nursing and midwifery workforce requirements to the Board
- Ensure appropriate training and education programmes are delivered and workload on workforce planning across the Board
- Ensure the provision of expert clinical advice in workload and workforce planning and support and facilitate teams to review workforce information in order to inform service redesign, development of roles, to ensure that services and workforce are responsive to needs of patients.

Outcome 2 – Working collaboratively with the National Programme Advisor to ensure the local needs are met and appropriate materials are available to support local implementation and legislative requirements.

Outcome 3 – Working collaboratively with local NHS Board Excellence in Care lead to ensure the quality aspect of triangulation is embedded in the common staffing method processes and principles.

Outcome 4 – Support the NHS Board to report to Scottish Government on how the duties within the Act have been achieved.

Outcome 5 – Ensure representation of the NHS Board at local and national forums, to influence, shape and contribute to the National Policy Agenda.

Formal work on safe staffing has recommenced as of 3rd August, and the local workforce lead is liaising with the Programme Advisor Healthcare Staffing Programme to identify and agree local priorities.

Culture, Values and Behaviours

10.14) Following on from the publication of the Sturrock review in NHS Highland in May 2019, considerable work has been undertaken to establish what issues are important and relevant to make individuals feel valued and supported within the hospital environment.

A series of themes from the Sturrock review were discussed through the Partnership Forum. Six core areas were identified for improvement; these were:

- Communication and Engagement
- Leadership and Management
- Human Resources
- Cultures and Behaviours
- Staff Support
- Governance

30 improvement areas were highlighted under the headings above. In order to address and improve the workplace experience for individuals, a dedicated sub group of the Clinical Model Oversight Board focussed specifically on Values, Behaviours, Culture and Leadership within TSH.

In light of the learning throughout the covid-19 response, the positive staff feedback and work of the current innovation and recovery output, this work will be refreshed in December 2020 to assess which aspects have been addressed and what issues are new.

National staff experience measurement 2020 – Pulse Survey

10.15) The National iMatter Staff Experience Continuous Improvement Programme was paused in recognition of the changing priorities in responding to the Covid-19 pandemic. The Scottish Government Health and Social Care Directorate have continued to work closely with Boards and engagement with stakeholders and SWAG Committee recognised that a national measurement of staff experience should be undertaken for 2020.

TSH are planning to implement the National Everyone Matters Pulse Survey as the Staff Experience Measurement for 2020. This will provide a meaningful opportunity for staff to express their views, with outcomes being used to inform wider staff experience, health and well-being, culture, dignity at work and work on equalities, diversity and inclusion programmes.

11. TSH Provisional Internal Restart Schedule

a) The undernoted table provides an update of the restart schedule of internal activities, following on from the previous version of remobilisation planning:

Process	Restart
Medical	
Clinical Model Service Delivery Implementation	December 2020
Supporting Healthy Choices Plan	Commenced – principles and plan
Research studies suspended with all fieldwork involving patients or staff	Digitally enabled
Hospitals Electronic Prescribing and Medicines Administration (HEPMA)	TBA -In line with external demands
Nursing & AHP	
Scottish Patient Safety Programme	August 2020
Infection Control Committee	Commenced
Medicines Incident Review Group	Commenced
Excellence in Care Steering Group	Await national restart
Safe Staffing Steering Group	August 2020
Person Centred Improvement Steering Group	Commenced
Child and Adult Protection Forum	Commenced
Security & Estates	
Major Security Upgrade	Commenced
Health and Safety Group	Commenced
Finance, Performance and Risk	
Policy Review Cycles	Commence in August – E-Review process
Monthly Audits of Record Keeping	Commenced
Clinical Audits	Commenced
Variance Analysis from Case Reviews	Commenced
Gap Analysis from National Evidence	Commenced
Significant Adverse Event Reviews	Commenced
Strategic Review of Performance	August 2020
NIS Audit	On hold
Human Resources	
Job Evaluation	Source external support
Organisational Change	Completed
Implementation of eESS	August 2020
Sickness absence Routine Reviews	Commenced
HR Connect	Commenced
Values Based Recruitment	August 2020
Non urgent employee relations cases	Commenced
Training and Development	Commenced E-training
Leadership Development	September 2020
Organisational Culture	Commenced
Team Development Programme	September 2020
Corporate Services	
Corporate Governance	In line with active governance development

12. The Skye Centre

12.1) The Skye Activity Centres have remained closed since 23 March 2020 in the context of covid-19 restrictions. During this period patients have had very limited access, namely:

- to the Health Centre to meet their physical health needs
- to attend the PTS and to participate in Court proceeding and Mental Health Tribunal appearances via video and tele-conferencing (to maintain confidentiality from the ward and hub environment)
- Patients have not been able to access the hospital shop, however, patients have been supported to submit weekly shopping lists with the items delivered directly to the ward. A £10 weekly shop top up is also accessible by all patients.

Skye Centre staff have been redeployed to facilitate daily escorted walks for patients across all wards and have also supported wider hospital activity i.e. Mental Health Tribunals, Court Video Conference, room searches, Patient Library and ensured that essential work related to the Animals and Horticulture centre is maintained.

12.2) The Scottish Government routemap broadly defines the range of services that might be expected under the various lockdown phases. We are now in phase 3 of the covid-19 route map. As the Skye Centre houses the majority of creative, recreational, spiritual and educational facilities, it is appropriate to consider the use of this facility over the coming months.

The routemap defines that 'some communal living experience can be re-started when it is clinically safe to do so.' During phase 3, any activities delivered within the Skye Centre will be delivered on an individual ward cohort basis. There will be no mixing of patients between wards considered until phase 4 of easing of lockdown restrictions has been implemented nationally.

12.3) The undernoted position has been reviewed and approved by Infection Control and STAG in relation to phase 3 of the routemap:

- The decision to expand the range of activities to include indoor Skye Centre activity requires to be cognisant of infection control measures and also the clinical care of patients must be maintained with safe staffing levels.

- In June 2020 it was agreed that outdoor activity could be provided by the Gardens and Sports & Fitness staff and this has been successfully delivered and enjoyed by the patients attending.

- Patient learning activities should be re-introduced at Hub and Ward level over 3 sessions each week. The initial phase has enabled staff to carry out Core Skills Assessments for recently admitted patients. This information provides the clinical team with standardised results with regard to basic educational level and the need for subsequent intervention to improve literacy and numeracy. Learning input has also been

provided for a small number of patients prioritised by their Clinical Teams. Activity data is recorded through the RIO patient timetable and included in the weekly report provided to the Monitoring Group.

12.4) With regard to specific use of the Skye Centre in phase 3:

Hospital Shop: There is no initial plans to allow patients to access the hospital shop located within the Atrium area of the Skye Centre. Consideration requires to be given to reopening this facility under the phase 4 stage of the routemap.

Atrium 'Drop In': There is no initial plans to allow patients to access the Atrium café area using the 'Drop In' facility. This would increase the risk of patients from different wards and hubs mixing indoor. Consideration requires to be given as to whether this can be accommodated under the phase 4 stage of the routemap.

Library Service: The Library service has continued on an individualised basis supported by the Librarian. This will continue to be the practice until phase 4 of the routemap.

Spiritual & Pastoral Care: The church services were held twice weekly in the Multi-Faith area. The numbers that previously attended cannot be accommodated in this space due to current guidance on physical distancing and the National Guidance related to religious services. This space will be used for individual prayer and reflection under phase 3 of the routemap.

Yoga: An external yoga instructor working in conjunction with the Phoenix Trust has provided blocks of yoga instruction in a group and individual format for the past 2 years. This activity is very well attended by patients. The reintroduction of group yoga will remain on hold until phase 4 of the routemap.

Sports and Fitness Hall

- Outdoor spaces will be used for activities weather permitting – Cycling, Tennis, Circuits
- The main sports hall will be used for all activities. All activities and equipment will be appropriately set up for use with physical distancing maintained.
- Patients will only participate in individual exercise and not in team sports; with the exception of table tennis, badminton and carpet bowls where appropriate physical distancing can be maintained.
- All patients will use the ABHR on entry and exit to the Activity area and can access hand sanitiser during the session. Hand washing facilities are available in the department.
- Staff will adhere to current guidance related to infection control and wearing masks within a clinical area
- Equipment will be cleaned before and after each patients use (gym equipment, bowls, racquets and balls).
- The changing/shower area will not be in use. Patients will come prepared for the session in appropriate clothing and footwear and will have the opportunity to shower in their own room on return to the ward.

Animals & Horticulture

- All equipment will be stored safely outside for patients use when they arrive.
- Patients will be designated individual tasks - this will allow patients to physically distance as different tasks will keep them apart.
- Outdoor areas and greenhouses have large spaces which allow physical distancing to be maintained during planned activities.
- Staff will adhere to current guidance related to infection control and wearing masks within a clinical area
- Indoors workshop - patients from the same ward will be designated individual tasks such as feeding the animals, fish, cleaning out cages. This will allow patients to physically distance as different tasks will keep them apart.
- Indoor Botanics – patients from the same ward will be designated individual tasks such as feeding fish, cleaning out fish pond, cleaning the area and tending to plants. This will allow patients to physically distance as different tasks will keep them apart. The botanic gardens is a large space which allow ease of use for planned activities.
- Hand washing facilities are provided in the outdoor area.
- All patients will use the ABHR on entry and exit to the Activity areas and can access hand sanitizer during the session. Hand washing facilities are available in all departments.

Patient Learning Centre

- Staff will adhere to current guidance related to infection control and wearing masks within a clinical area
- Patients will access individual paperwork in their own files.
- Computers can be used as normal with appropriate cleaning before and after each patients use.
- Room layout has been considered to ensure physical distancing is adhered to.
- All patients will use the ABHR on entry and exit to the Activity areas and can access hand sanitizer during the session. Hand washing facilities are available in all departments.

Craft and design

- Each patient will have their own designated art materials such as paintbrushes, clay, paper and pens. Activities offered will be patient led with staff support whilst physically distancing.
- Where sharing of resources may be required such as with modelling tools, then they will be cleaned before and after each person's use. Any items, which cannot be appropriately cleaned, will not be used.
- Demonstration on techniques will be done at an appropriate distance and staff will not contribute to a patients art work such as clay. Items such as clay will not be shared.
- All patients will use the ABHR on entry and exit to the Activity area and can access hand sanitizer during the session. Hand washing facilities are available in all departments.
- Staff will adhere to current guidance related to infection control and wearing masks within a clinical area

Any further relaxation of activities within the Skye Centre will be approved through the STAG and command process.

13. TSH DIGITAL TRANSFORMATION

13.1) Considerable gains have been made in the use of digital technology. In light of Covid-19, TSH e-health teams have worked at a remarkable pace to progress technological solutions and enable effective remote and flexible working.

Additional laptops have been purchased, Near-me technology installed, remote access enabled, teleconferencing links established - all to enable effective flexible working and enhanced patient and visitor experience.

Considerable work is still required, for example many laptops do not have a sound or camera enabled functionality. An assessment of all kit has been undertaken and a list of priorities have been agreed. This may require additional and unplanned expenditure in the coming year. This will however be necessary to allow the organisation to effectively work under the 'new normal' arrangements.

With the ever growing demands on the requirements of digital innovation, the structure and plan to deliver needs to be put in place. These are important for the needs of TSH and national direction. The main priority areas and key projects are noted below, whilst these will not be completed within the six month span of this plan, they are important to cite nevertheless.

Key Projects include:

Laptop & hardware replacement - In order to ensure we take full advantage of digital technologies the equipment we deploy needs to be capable of supporting it. The life span of most IT equipment is 5 years at which point it should be retired and ethically disposed of under the WEEE regulations. In order to follow this process capital funding requires review.

Remote access - At present TSH have 50 users of the service with no significant impact to the hospital's internet connection reported. The number of staff now using this service is double what was anticipated and we are continually monitoring the use of the service to ensure stability continues. The demand on this service will grow as new ways of working are taken forward. Future demands in this service would need additional bandwidth to ensure remote access is always available. It may be impacted by the increased demand on access to digital education and resources now only found online. Additional bandwidth would ensure the impact of this on remote working is limited as the consumption of online education and research resources increase.

Wireless Network Replacement - The existing wireless network is now coming to the end of its lifespan. This was the first innovative eHealth system installed that enabled mobile working within the hospital. This was seen as a significant change to how staff worked and is now fully imbedded into everyday working. Although coverage was limited at first it has grown in scale and is now used for the connectivity of not just staff laptops but the Patient Movement and Tracking System (PMTS), mobile language translators, tablets used by patients and the limited patient electronic catalogue access. The technology that provides this connectivity is still in support for the moment but is no longer comparable with modern wireless networks offering faster speeds and increased security.

It could also potentially provide future ability for selected patient use with certain smart devices subject to review of additional security controls – only after appropriate consultations with multi-disciplinary teams.

Software - All software has a lifespan and will need upgraded over time to ensure it security and stability. The various systems used by the hospital require periodic upgrading to deliver the best results for our patient care and staff. While software support, maintenance and licensing has previously been provided on an initial investment basis when systems are new, manufacturers are now tending to move to a revenue funding structure over the period of support.

Windows 10 - Laptop users will now be the first to be moved over to Windows 10, with desktop users addressed in the second stage of the rollout, including consideration of moving to laptops where this option is preferred. Having Windows10 fully rolled out will allow TSH to fully benefit from the functions, security and collaboration capabilities of Office 365.

Office 365 email migration - Initial technology prerequisites are in place but this now needs to be tested. The date provisionally provided for TSH move is 8th September 2020. There is considerable work to be completed to prepare for this.

Office 365 implementation - An Office 365 project group is underway, as the final part of TSH move to O365. Work undertaken with Teams and email rollout is essential to the success of this part of the project

eRoster - This national project is still in the early stages of national procurement. Once this process has finalised, TSH has been identified as an early adopter of whatever solution wins the tender.

Hospital Electronic Prescribing and Medicines Administration (HEPMA) - HEPMA will allow the safe move from paper prescribing and administration to an electronic prescribing and medicines administration system. This is being taken forward in collaboration with NHS Lothian.

13.2) Business Intelligence is relatively new to TSH, but the benefits it has already delivered are considerable.

Tableau - Development is progressing. TSH have made significant progress on new and existing dashboards and these will continue to be rolled out across the hospital once user testing has been completed.

RiO - (Patient Medical Record) TSH have the opportunity get more from RiO if we upgrade to the latest version with additional functionality. This will be evaluated to assess the full costs and benefit potential.

13.3) Caution has always been taken with patient access to digital technology. TSH has been changing this with the delivery of a new patient learning network and access to tablet based digital solutions. Security is paramount with any digital solution for patient use and to ensure this eHealth will ensure support and assistance with Estates and Security.

On-line Education - Work was recently completed to allow patients attending the Patient Learning Centre the capability to sit testing securely online. This has been a significant achievement with eHealth and the PLN staff in the Skye Centre working together to deliver this. Collaboration now continues with PLN staff on the increasing level of other patient training needs that can only be assessed online.

Patient Electronic Catalogue - Access to electronic catalogues for patients has been challenging due the concerns around security and the availability of eHealth staffing. .

13.4) As a public body the Board has several legislative responsibilities. Significant among these are GDPR (General Data Protection Rules), NISD (National Information & Security Directive) and the National Records Management Plan. TSH are actively working toward meeting all these requirements and these will require ongoing investment. With increasing digital working, policies and procedures must develop to meet these requirements.

NIS - The Network Information Security Directive is not just the responsibility of eHealth but of every department within the Board. eHealth have the largest part in delivering NIS but all departments need to prove the digital security processes of suppliers are considered as well as the procedures and policies for and storing digital information. TSH will be audited yearly for compliance.

Records Management Plan - The development of TSH Records Management plan has been ongoing for some time. Once in place it will ensure all records are legally held by the Board and only used for the original intention when they were created. It will also provide a retention date for different document types, and information on when this date has expired – plus disposal procedures and guidelines to ensure we meet our legislative requirements.

14. TSH Resilience Planning

14.1) The Annual Operating Plan for 2020/21 outlined a twelve month schedule of resilience planning milestones for TSH in 2020:

2020 Training Programme	J	F	M	A	M	J	J	A	S	O	N	D
Commander Training	■		■									
Staff Officer and Bronze Training	■		■									
Golden Hour		■										
Golden Hour Refresher	■											
Loggist / Board Communications		■	■									
Loggist and Silver Commander		■	■									
Communications and Board					■		■					
Security Reception Staff	■	■	■	■	■	■	■	■	■	■	■	■
Table Top	■		■		■		■		■		■	
Clinical										■		
Multi Agency Exercise										■		

In light of the covid-19 pandemic, this plan will need significant modification. A review process of the effectiveness of the command and resilience structure is scheduled for 08 August. This will further inform any improvements or amendments. The training programme will be amended accordingly based on the output of this event.

14.2) Resilience arrangement are working effectively since the command structure was stood up in March 2020. Two events have necessitated a further stand up of major incident arrangements:

- 15 May – A siege and barricading response incident was stood up on 15 May 2020. The response required multi agency support. Support was swiftly deployed by Police Scotland and the Scottish Ambulance Service. The event had a satisfactory conclusion with the incident being resolved in around three hours from start to finish.

- 19 July – An incident occurred in the early hours of 19 July which required a multi-agency response. This was resolved with assistance from Police Scotland.

Adverse Event Reviews are being undertaken for both these incidents and any learning form the events will be shared.

14.3) TSH will enact resilience plans already developed. The Loss of Staff Level 2 Resilience Plan identifies the key processes and contingencies essential for the safe operation of the hospital. However a plan for managing 'Extreme Loss of Staff; has also been developed and approved through Gold Command. This builds on the 'Loss of Staff Plan' already agreed for the hospital. The priority of the organisations' response to loss of staff is to ensure safety, security and care for patients and staff.

Key processes that will be prioritised throughout any second wave or pandemic resurgence are personal care to patients, medical care to patients, site security, provision of food, ward and site cleanliness and maintenance, maintenance of information systems and essential transportation across the site. The Extreme Loss of Staff Plan:

- Identifies contingences to be taken at points of criticality for safe delivery of service during covid-19 outbreak
- Identifies where staff may be deployed to in the event that departments fall below minimum tolerable numbers to deliver a safe service
- Identifies any areas of training that may be reasonably carried out in advance to up skill or orientate staff to departments and roles they may be asked to support
- Considers how the organisation can gather and review staffing across all disciplines to enable effective planning
- Identifies IT needs to support remote working for those staff who can work from home

The plan has been completed and a desktop exercise was undertaken on 18 May 2020 to stress test the assumptions. There has been no requirement as yet to enact this plan.

14.4) Incident Command refresher training took place on 09 July for all Directors performing on-call roles.

15. Security Upgrade

15.1) As part of the Board's normal forward planning it was identified that some of the hospital's security systems will require replacement due to increasing age. The Board's efforts are always directed towards the security and safety of Patients, Staff and the General Public. This work will continue the Hospital's excellent record of providing safe and effective care and treatment within the High Security environment.

15.2) A Business Case was developed and then approved by the Scottish Government. It ensures that the hospitals security remains in line with best practice for the future. It addresses systems replacement and improves others with the use of the latest available technology. The contract for undertaking this work was awarded to Stanley Security Solutions Limited after a competitive tender process.

The Security Upgrade has commenced and will be completed over a two year period. This includes:

- Replacement and enhanced CCTV features
- Upgrading and extending cameras, surveillance and detection systems
- Replacement of staff safety attack alarm system
- Upgrade of the Security Control Centre
- Upgrade of the radio communications system

16. CORPORATE GOVERNANCE

16.1) In March 2020, TSH reviewed the corporate governance framework for the NHS Board to ensure effective oversight during the covid-19 pandemic. This review was conducted within the requirement of existing legislation, and in reference to the existing Standing Orders of the Board. The aim was also to identify new emerging risks within the corporate governance framework as well as options to mitigate these risks.

The recommendations from the report are summarised as follows:

- Board meetings should continue on agreed schedule, and that special meetings can be convened as required. The business transacted at the Board will be reviewed to allow oversight of the Covid-19 response as well as resilience of the senior leadership team to provide reporting to the Board during this challenging time.
- Governance Committee meetings should be critically reviewed and may be paused depending on the emergent situation in managing the response to covid-19. If the situation arises where a meeting is not quorate then it would be the intention to reschedule to the earliest possible date.
- Any divergence from the agreed work plans for the Board and its Committees, should be recorded in the minutes of the meeting appropriately.
- The Board should note the risk to achieving required quorum for Board and Committee meetings.
- All Board and Committee meetings should be held virtually.
- There is no requirement to amend existing Standing Orders.
- This position should be reviewed by the Board in six months' time, or sooner should the global pandemic situation change significantly.

Following agreement by the Board to each of these recommendations, this position was reported to Scottish Government on 1 April 2020.

16.2)The Board and associated Committee Structure will continue to meet in accordance with their agreed schedule. Workplan modifications to reflect the covid-19 situation will continue to be agreed with the associated chair. The focus of agendas for each meeting will be considered and adjusted appropriately to reflect the ongoing pandemic and the response required with specific reference to the remit of each committee. The TSH Board has underlined that this position should be kept under close review should the global pandemic situation change significantly.

In addition, the non-executive members of the Board will continue to meet regularly with the Chair and Chief Executive, and receive updates on the Interim Clinical and Support Services Operational Policy. The Chair and non-executive directors also receive the hospital covid-19 communication briefs to keep them informed of the changing landscape across the organisation at this time

Board and Committee Meetings have been held virtually rather than in person, to date, to comply the need for non-essential travel and physical distancing. The preferred mechanism is now through MS Teams in line with other NHS Boards. It is acknowledged that this mechanism has not yet provided a clear solution for inviting members of the public and the media to attend public board meetings. Prior to the pandemic situation, this was an area of active interest for the TSH Board to encourage public interest and attendance at public board meetings, as part of the NHS Scotland Blueprint for Good Governance workstream. The State Hospital will await further guidance from the NHS Scotland Corporate Governance Steering Group who are now leading on development of a national approach to ensure consistency across NHS Scotland.

The Board Schedule for the remainder of 2020 is as follows, and the Board will review its schedule for 2021 at its next meeting on 27 August to ensure agreement on this by October 2020.

	April	May	June	July	Aug	Sept	Oct	Nov	Dec
Board	23rd		18th	2nd	27th		22nd		17th
Clinical Governance		14th			13th			12th	
Staff Governance		28th			20th			19th	
Audit Committee			18th				8th		

Due to the need to respond to the Covid-19 pandemic, the TSH Board has agreed to pause implementation of the new Clinical Model, and therefore has also agreed to pause the Clinical Model Oversight Board during 2020. 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 restarted with the Medical Advisory Committee meeting regularly, the Nursing and Allied Health professionals Committee planned to recommence on 01 September, and the Psychology Practices Group restarting on 24 August. The Clinical Forum will re-engage in August 2020.

16.3) Partnership working has been strongly supported through the Incident Command Structure as well as through continuation of the Staff Governance Committee. The Employee Director and nominated deputy from Joint Staff Side attend Silver and Gold Command; and the Operational Partnership Group (a sub-group of the Partnership Forum) was remobilised on 14 July 2020. It is planned that the Partnership Forum will formally reconvene once formal stepping down of Incident Command has been agreed and implemented.

As part of re-mobilisation across NHS Scotland, work is underway through the Corporate Governance Steering Group, and Corporate Governance Programme Board on the Blueprint for Good governance and a 'Once for Scotland' governance model that will deliver a consistent, coherent and cohesive approach. This will continue through leadership on 'Active Governance' across NHS Scotland.

The State Hospital welcomes the 'Active Governance' initiative, noting that this will comprise of two substantive and linked components:

- Assurance information system to ensure NHS Boards have the necessary information system to give assurance on performance delivery including strategic, operational and financial plans, benchmarking performance against similar organisations.
- Design and develop a development programme for Board Members to ensure they can engage with assurance information to inform decision-making and identify substantive issues that could detrimentally affect the organisation's culture, performance and reputation.

Prior to the pandemic, the TSH Board self-assessed its own performance and implementation of the Blueprint for Good Governance and received monitoring reports at each board meeting. This workstream was paused in March 2020, and will recommence in September 2020 allowing reporting to the TSH Board at its meeting in October 2020. This will enable linkage to the 'Once for Scotland' approach nationally and the key aspects of this refreshed approach through 'Active Governance'.

17. FINANCE

17.1) The financial implications are an integral part of the remobilisation planning process as noted by the Scottish Government Director of Planning's letter of 3 July 2020.

17.2) TSH met the statutory financial targets as set out for March 2020 financial year end with no significant risks highlighted and are forecasting achieving these for March 2021 year-end. For 2020/21, the Hospital has now identified and specified additional costs which are regarded as being covid-19 specific, and these are specified in this plan as the Hospital continues to operate under new ways of working. These costs as summarised below under "Pressures" are reported on a regular ongoing basis to the SG Health Finance and Infrastructure team.

17.3)There is a requirement to generate efficiency savings year on year. This is cash releasing savings to match the increased costs and productivity savings to deliver against the increased demands of patient care including complexity, activity increases and the requirement to continually invest in technology and quality improvements. Year on year TSH has successfully achieved and delivered in excess on its challenging efficiency target.

- Savings targets have been met in each of the recent years. In future years, it is likely that TSH will have increasing challenges generating the same level of cash releasing savings. In order to ensure that service delivery can continue to improve and develop, the focus is required to move to improvements in operational efficiency. This will require new approaches to driving and monitoring efficiency, including the introduction of a new Clinical Model in 2020.

Financial Planning 2020/21

The financial plan sets out the resources available to the Hospital and how these will be used, and includes regular funding planning assumptions as follows:

- Scottish Government RRL baseline budget as described within RRL allocation letter and Scottish Budget, including a baseline funding uplift of 1%
- Consideration has also now been given to the financial consequences of the Board's remobilisation plan in order to identify specific covid-19 related costs – for allocation by Scottish Government as part of their share of the provision from the UK Treasury.
- These additional costs arising specifically from the covid-19 crisis are being reported regularly to SG with submission of national templates. Funding allocation in relation to these costs is expected to be assessed and notified to Boards based on the return for Months 1 & 2 (submitted 17th July 2020) and that for Quarter 1 (due for submission 14th August 2020). The principal costs for the Hospital in this regard are noted below.
- Planning assumption that central funding support will be provided above the first 1% of pay award for Agenda for Change grades only. (With the high level of staff costs as a proportion of the Hospital's overall allocation, a movement of 1% funding against staff pay has an impact of £300k on financial pressures.)
- Key assumption regarding staff costs that the nursing overtime costs – which created financial pressures in prior years – are now operating at an ongoing sustainable level within budget, which is to continue into 2020/21 with the implementation of the new Clinical Model.
- During 2019/20 there were costs incurred with regard to the ruling from the Locke v British Gas case – "PAIAW" (Pay As If At Work). In this regard there were costs now paid which were Scottish Government funded, but there remains pressure for the unfunded element of this cost into 2020/21 (£140k approx.), and also the risk of any future claim extending the period for which the ruling initially applies.
- For staff who are not superannuated, the auto-enrolment in late 2019 has potential for added financial costs should those individuals not opt-out – while this opt-out option is not yet concluded there is a risk of pressure of £336k approx.
- Savings contribution towards National Boards' £15m requirement continuing at a level of £220k per 2018/19 and 2019/20.
- Continued support towards eHealth leads and eHealth allocation (£215k approx.) from former Outcomes Framework allocation (£33k approx.) – there is a risk of delivery of eHealth projects being adversely affected should there be any significant reduction in the allocation of strategic funding.

- Specifically within eHealth, the national Office 365 project is a significant issue for 2020/21. As this is still in the evaluation stage at a national level through the Corporate Finance Network and other National Groups, the potential financial pressure is not yet quantifiable – although it should be noted that it will arise from both direct cost pressures and staff resource pressures.
- Consultant Distinction award funding reflecting submission to the Scottish Advisory Committee on Distinction Awards (SACDA)
- Funding to support Implementation of Excellence in Care (£40k approx.), MH (Mental Health) Secondment and Disabled Graduate scheme (£ values awaited)
- The Hospital's legal costs have risen due primarily to work on the Perimeter Security Project and on a small number of cases requiring significantly more time than has historically been the position. Cost pressure of £80k approx. is therefore noted for 2020/21.

The table below contains an extract of the Hospital's three year financial plan – and the main pressures and risks behind the plan are in the following section.

Remobilisation Plan / Annual Operating Plan	2020/21	2021/22	2022/23
Income	£'k	£'k	£'k
Core RRL	34,883	36,178	37,240
Covid-19 specific – per SG return re allocation review*	1,412	-	-
Non-core RRL - Capital Charges	2,857	2,857	2,857
Non-core RRL AME**	112	112	112
Total Income	39,264	39,147	40,209
Expenditure			
Pay	33,387	32,870	33,799
Capital Charges	2,857	2,857	2,857
AME* Provisions	112	112	112
Non-pay	5,808	6,033	6,133
Income	(1,578)	(1,225)	(1,260)
Savings	(1,322)	(1,500)	(1,432)
Total Expenditure	39,264	39,147	40,209

* Covid-19 costs included for SG allocation review are split between pay (£1,088k) and non-pay(£324k) expenditure
**Annually Managed Expenditure

Overall position

17.5) The financial plan is balanced and delivery of a breakeven position during 2020/21 remains dependent upon recognition of the funding pressures of the covid-19 costs incurred, and realisation of the savings plan. Financial risks remain high around the workforce plan skill mix and staff rostering, with risk also around the level of 2020/21 savings unidentified, which contributes to a high risk of financial shortfall should these be unachieved.

Pressures – Covid-19 specific costs

17.6) Due to the covid-19 crisis, as noted above, the principal additional costs arising from the crisis relate to staffing and IT – being increased overtime costs due to higher staff absences and the increased hours of key staff working as part of the covid-19 team; the costs of "dual-running" critical posts within the hospital arising from the demands on roles for which staff have been redeployed to the covid-19 support team and related work; and the cost of IT equipment etc. required to enable staff connectivity through the crisis.

- The main costs noted in our covid-19 template returns are as follows:
- Overtime costs April £150k, May £80k – additional overtime is incurred each month due principally to the increased levels of staff absence, together with an element of high level clinical demands. These costs are ongoing throughout the timeframe of the current crisis.
- Covid-19 support team £35k per month / Dual running staff costs (August 2020 – March 2021 approx. £258k)
- In March the Hospital established a specific team to provide support to the management of the Covid-19 crisis, comprising 9 members of staff seconded from various departments – this team will continue to operate as a key part of the Hospital's remobilisation. While these costs are effectively offset within each team member's own departmental budget, there is now the requirement for the backfilling of their roles which is noted below as an essential covid-19 cost arising from "dual running".
- Dual running staffing costs – these relate to staffing restructure or additional posts which are urgently required from the ongoing crisis. While the Covid-19 support team is in place, those staff are all redeployed from other departments – where their normal workload is either stalled or undertaken by others in the team, with no backfill in place, and this is now being addressed as a priority.
- IT costs £20k – additional equipment (laptops, mobile phones, licences etc.) necessary in order to facilitate remote working for a number of staff and other essential IT site requirements.
- Costs for deep cleaning, drugs, oxygen, specific equipment, and increased teleconferencing – approx. £10k per month during the crisis.
- Delayed annual leave £44k – increased year-end accrual for staff leave due in March now deferred due to staff required to be on-site or absent through sick leave.
- Equipment costs £8k – this includes new monitors, some pandemic PPE stock, uniforms, and patient TVs/radios.
- Estates/facilities costs £6k – including the requirement for additional lockers, trolleys, chairs etc.
- Recruitment of an additional 12 student nurses on 6-month contracts – due to be funded by NES - as part of a national initiative to support Covid-19 pressures – estimated cost for 6 months £260k (£43k per month) – currently these are noted as offset costs with the expected NES funding.

Pressures – other

Other pressures facing TSH over the coming year include:

- Workforce Plan Numbers and Skill mix - due in part to the fall in staff turnover, it has not yet been fully possible to achieve the planned workforce. The issues relate mainly to nursing costs. The full workforce plan aligned to the clinical service delivery model and safe staffing legislation is under review as previously highlighted, to link with the review of the Clinical Model. There is also pressure from any unfunded element of increased payroll costs, e.g. executive pay.
- Payroll impact from the 2019 outcome of the legal case "Locke vs British Gas" and the potential liability for additional shift payments required.
- Potential increases in rates.
- Utility costs continuing to rise, giving both a price and usage pressure in 2020/21.
- A number of costs associated with the Hospital estate upkeep, all monitored closely and outturns adjusted accordingly. Ongoing evaluation of this impact over the coming years is assessed for budgetary pressures to be controlled.
- As noted above, the requirement for the National Boards to provide additional savings of £15m (plus any unachieved savings carried forward from 2019/20) on a recurring basis in 2020/21.
- Savings plans – as stated above the operational running costs of the site are more than planned. A savings plan around the workforce, capital charges and supplies may need to be enhanced if the on-going costs of the covid-19 crisis, and (when implemented) the new Clinical Model are more than

forecast. Also year on year it gets harder to identify workforce savings without impacting on patient care or security. If plans fall behind the financial balance could be at risk unless other non-pay savings can be found.

TSH manages pressures and risks on a regular basis – formally monthly, or weekly where required.

Savings

17.7) There are continued efficiency and productivity improvements sought which will be identified, managed and implemented through this period. Savings targets for 2020/21 are particularly challenging as the Hospital manages the pressures noted in the next section.

It is important to note that in 2019/20 it was highlighted that the Board had the highest proportion of staff costs to total costs (85%) when compared to all other boards – thereby significantly reducing the proportion of non-pay costs which can be reviewed for recurring efficiencies to only 15% of budget – which is a much lower level than that for any other patient-facing Board.

The key areas identified to date from discussion with budget holders are

- Service redesign – planned efficiencies identified from forthcoming expected revisions to service delivery. This includes a review underway – in conjunction with the implementation of changes to the Clinical Model – which is addressing all service areas and the optimum structure for service delivery. We are therefore exploring all opportunities for structural efficiencies which can be addressed at the same time as the restructure of the clinical delivery.
- Drugs / prescribing – identified efficiencies from drug pricing and planned patient numbers – we continue to work NHS Lothian to ensure any potential further efficiencies are realised.
- Workforce – this is the key area for the Board's planned savings, and relates to both the recurrence of annual vacancy management and the resultant timing of recruitment; and as noted above the planned implementation of the new Clinical Model in early 2020/21 for which potential annual efficiencies amounting to between £195k and £535k (dependent upon shift pattern reform) were outlined at the options evaluation stage within the Nursing workforce. We are also confident that – while all vacancy savings are categorised as "non-recurring" due to relating to different posts from one year to the next – there is nonetheless an underlying "recurring" level of vacancy savings to be realised each year, as to be expected from the level of staff turnover which arises each year in an organisation with our staffing levels.
- Infrastructure – planned efficiencies in housekeeping, kitchens, estates and research – these departments are all currently engaged in full reviews of their optimum infrastructure requirements, including the impact of new ways of working arising from the covid-19 crisis and the new clinical model, from which efficiencies are anticipated to be realised in 2020/21.
- Other – planned efficiencies in reserves and provisions.

Progression against the savings trajectory for the year is monitored on a monthly basis through the Corporate Management Team, Organisational Management Team, Partnership consultation, Board reporting and direct meetings with all individual budget holders.

The post-implementation review of new ways of working arising from the Covid-19 crisis, and the Clinical Model review will assess the recurring impact therefrom, and TSH will continue to assess with executive leads how a greater contribution of recurring savings can be identified as early as possible through budget review meetings and delivered in 2020/21

Collaborative working

17.8) The Board is working collaboratively with NSS with regard to accounts payable and receivable, and with overall support to the resources and demands of the finance department, including current collaboration facilitating departmental restructuring; and with NHS Greater Glasgow & Clyde for the full provision of payroll services.
Other collaborations already in place include:

- Social Work Services - South Lanarkshire Council
- Pharmacy supplies - NHS Lothian
- Human Resource support - NHS Lanarkshire
- Occupational Health Service - NHS Lanarkshire

Each of these collaborations operationally provides a significant resource benefit to each of the relevant departments, and directly strengthens their flexibility and resilience.

Capital – Property and Assets

17.9)The significant capital item forthcoming is the Perimeter Security and Enhanced Internal Security Systems Project. (2020/21 -2021/22) estimated at £8.4m. This project is currently underway, with the only covid-19 related risk being that in the event of any further unforeseen lockdown restrictions, there may be an impact on the contractors' access to the Hospital site causing a delay in their work. This is noted on our covid-19 financial return as a potential risk, with an estimated delay cost of approx. £60k per month, should such a delay occur later in 2020/21.

Other capital items – principally vehicles (£75k in 2020/21), IT equipment (annually £75k approx.) and Secure Rooms (£200k approx.) in the Hospital Wards – are monitored through the Capital Group's three-year forecast and are currently fully addressed within that budget. The lack of any recurring increase in capital funding potentially leaves equipment replacement at risk, as the formulae allocation requires close control and review to be able to cover any major equipment replacement programmes.

TSH will focus on capital priorities on a monthly basis via the capital group ensuring estate spend is directed where required within a five year capital planning programme.

APPENDIX 1: LINKAGE

National Chief Executive Officers

TSH is a participant in calls with national Chief Executive Officers and the Scottish Government Health Department. TSH also participates in a weekly call with National Board Chief Executive Officers.

The aim is to ensure that the organisation is aligned to the emerging national direction and service model associated with the NHS Scotland response. The agenda remains dynamic as it addresses new and emerging themes associated with national priorities and core direction. TSH will remain aligned to this model as the key mechanism for national oversight and strategic alignment within NHS Scotland.

The process works well and participation will continue.

National Medical Directors

TSH is a participant in the national conference calls with Medical Directors. Linkage with CMO office takes place through the National Medical Directors calls.

Recommendations on medical practice areas, ethical debates and shared communications are endorsed through this route.

National Nurse Directors

TSH participates in weekly SEND conference calls which are specifically focused on planning and delivering SEND's contribution and response to Covid-19. This is focused on key issues such as infection prevention and control, workforce and remobilisation, and the frequency of the meeting reflects the rapidly changing agenda. Monthly meetings of SEND also continue, as does regular meetings between SENDs and the Chief Nursing Officer and her team.

These regular meetings are working well in ensuring connectivity and consistency on a national basis, and in ensuring translation of national priorities and direction into TSH.

National Finance Directors

TSH participates in calls with the national Directors of Finance, including representatives from Scottish Government Health Finance & Infrastructure addressing issues including development, structure and reviews of mobilisation plans; consistency of reporting, budgeting and forecasting; funding allocations; capital spending; and year-end accounts closures and timings. There is also participation in a weekly call of the Corporate Finance Network, and regular calls with the National Boards Directors of Finance Group.

In addition, the departmental heads of eHealth, Procurement and Finance are participating in regular calls with their respective networks and Heads of Service colleagues. This ensures that TSH strategy in these disciplines is also aligned with the national approach and that any national initiatives are fully addressed and communicated as required, with any national support and sharing opportunities fulfilled timeously.

These participations are working well and providing useful opportunities for sharing and development, and will continue through the weekly processes.

National Directors of Planning

The National Directors of Planning have representatives from territorial and national Boards and regional planning hubs. TSH attend meetings which now take place on MS Teams platform. The Chair of the group represents Directors of Planning on NHS Board Chief Executives group and collaborates with Scottish Government on planning and modelling for Covid-19.

National Human Resource Directors

TSH participates in monthly teams calls with the national Directors of Human Resources with the fundamental purpose of:

- As professional Heads of Workforce, work with the Scottish Government to drive, inform, shape and define Human Resources and Organisational Development policy, strategy and key priorities for NHS Scotland towards 2030
- Lead the implementation of developed and agreed workforce strategies delivering on the 2020 Everyone Matters Workforce Vision and key priorities, shaping the Workforce Vision for 2030
- Work collegiately as a group to provide leadership and direction, delivering change at best practice level, fostering innovation and driving quality improvement in HR & OD practice
- Enabling NHS Scotland to have an affordable, sustainable, skilled, adaptable and healthy workforce to deliver high quality centred care and services by defining, driving and supporting consistent implementation of NHSS workforce strategies.

In addition TSH participates in bi monthly strategic teams calls with the national Directors of Human Resources and Senior leaders within the Health Workforce Directorate. This ensures that TSH strategy for Human Resources and Organisational Development is aligned with Scottish Government policy and priorities.

Lanarkshire Resilience Partnership

Lanarkshire Resilience Partnership stood up its arrangements on Friday 13 March 2020. The group which includes Chief Officers from all statutory and voluntary organisations are committed to supporting each other in managing the emerging threat from COVID 19.

The group meets every two weeks and offers TSH the opportunity to escalate local issues that cannot be managed through the SGHRU (Scottish Government Health Resilience Unit) and other partner arrangements.

Scottish Government Health Resilience Unit

TSH participates in conference calls with the SGHRU and can escalate a broad range of Covid-19 related matters identified via the hospitals command structure. To date, issues regarding guidance on staffing issues, management of patients and supplies of PPE have been progressed via this arrangement.

High Secure Providers in NHS England: Clinical Secure Practitioners Forum (quarterly meeting)

Contact has been maintained with the three High Security Hospitals in England to ensure where possible there is a consistency in approach to the overall management of High Security environments.

Matters highlighted to date include search procedures, management of patients and access of visitors. TSH as previously stated, have alerted the search mechanisms for entering the Carstairs site.

National PPE Oversight Group

TSH participates in scheduled conference calls where NSS provide updates on PPE within NHS and the Health and Social Care sector. This affords the opportunity for TSH to escalate issues and also to receive updates in respect of supply and demand issues across the nation.

APPENDIX 2: THE COMMAND STRUCTURE

The State Hospital Incident Management Structure

Responsibilities of the Strategic (Gold) Team

To dictate the policy on recovery
To devise a long term strategy
To take major financial decisions
To liaise with senior managers and communicate with staff
To coordinate a media response, sign off statements and monitor the media strategy
To ensure recovery is in line with long term interests of TSH
To take ultimate ownership of the operation
To decide when to close down the incident

Responsibilities of the Incident Command (Silver) Team

Coordinate the recovery of operations across all disrupted areas
Coordinate communication with stakeholders including all staff
Forms a team to deal with ongoing incident and any unforeseen consequences
Develops a recovery strategy
Informs the Strategic Team of the impact of the incident on the service.
Allocate resources and resolve any conflicts over resources
Coordinates incident management
Liaise with HR over prioritisation of services, redeployment of staff and trade union issues
Advises on the closing down of the incident
Coordinates the incident report, debrief and review

Responsibilities of the Departmental (Bronze) Teams

Implement the Resilience Plan as directed by the Incident Command Team
Communicates with their staff on site
Appropriate stakeholder communication is agreed with the Incident Command Team
Keep the Incident Command Team informed on the progress of events and the impact on operations
Rationalise departmental resources in an attempt to minimise the impact upon the service.

APPENDIX 3: CURRENT PATIENT ACTIVITIES & UPTAKE

Activity	21st July	22nd July	23rd July	24th July	25th July	26th July	27th July
Art:1-2-1 Psychotherapy		4	3				
Dietetic:1 to 1		2		1			
Diet: Assessment	1						
DT: Drama therapy 1:1	1	2					
DT: Drama therapy Group	3						
Gen: CTM/Tri/CPA		1	1				
Gen: Court			3				2
Music Therapy: 1:1			4	5			
Nur 1:1	13	14	33	19	11	19	20
Nur: Card /Board Games	5	2	1	1	6	7	3
Nur: Computer Games	5	4	9	11	14	7	10
Nur : Craft Activities							5
Nur: Hub Gym		14	15	4	2		22
Nur: Patio Activities	4	1	6	18	4	2	
Nur: Walking	9	10	13	27	18	15	27
Nur : Laundry	7	8	11	8	8	16	19
Nur: Pool		7					
Nur: Table Tennis	1						2
Nur: Film Night			3				
OT:1-2-1 Session	7	5	5	5			1
OT:Group	14	21	2	3	3		
OT: Hub Club		2					
OT: Walking 1-2-1			1		3	6	1
OT: Walking Group	2				3	4	
Psych: Walking Grounds	2	1		7			
Psych: Admission Assessment	1	1					1
Psych: Awareness & Recovery		2	1	1			
Psych: CBT Other		1	1	5			1
Psych: CBT for Psychosis		1					
Psych: Life minus violence			1				
Pych: Looking after yourself	2		1				
Psych: Mentalization Based Therapy	2	1		2			1
Psych: Relaxation Group	6			5			
Psych: Talking Group	3		2				
PS: Therapeutic Milieu		7					
Skye Centre: Animal care	4						
Skye Centre : Bikeability	8						
Skye Centre : Grd		8	5				4
Skye Centre: Grd 1:1							1
Skye Centre: Grd Maintenance	4						
Skye Centre : LT-Grd			3				2
Skye Centre : Gym		1					
Skye Centre: Special Events		3					
Skye Centre: Walking 1:1	55		1	46	25	36	
Skye Centre: Sports 1-2-1		3	5				
Skye Centre: Volunteer Role Library	2		1				
Speech & Language Therapy:121 Communication	6		2				4
SLT: swallow							1
Total	**167**	**126**	**133**	**168**	**97**	**112**	**127**

APPENDIX 4: RESEARCH ARTICLE

BJPsych Open (2020)
6, e62, 1–10. doi: 10.1192/bjo.2020.40

Exploration of morbidity, suicide and all-cause mortality in a Scottish forensic cohort over 20 years

Cheryl Rees and Lindsay Thomson

Background

Premature mortality among patients experiencing forensic care is high. This paper examines the morbidity and mortality of all Scottish high secure patients in 1992/1993 and followed up 20 years later through the context of recovery.

Aims

To explore morbidity and delineate which patients are at greatest risk of premature mortality. To assess the extent of suicide and unnatural deaths. To establish which factors, if any, appear protective.

Method

Health and mortality data were extracted from national data-sets and death categorised as premature or post-expected age. Standardised mortality ratios were calculated to explore natural, unnatural and suicide deaths with Cox regression conducted to explore baseline demographics and premature death.

Results

During a mean follow-up of 21.1 years, 36.9% ($n = 89$) died, at an average age of 55.6 years. Of these, 70.8% ($n = 63$) died prematurely. Men lost on average 14.9 years and women 24.1 years of potential life. Five lives (5.6%) were lost by suicide and three (3.4%) by unnatural means.

Conclusions

In contrast to other mainstream and forensic cohorts, high rates of suicide and accidental deaths were not apparent. Risk of premature mortality is high. A greater focus upon physical health by community and in-patient services is essential.

Keywords

Forensic mental health; premature mortality; unnatural death; morbidity.

Board Paper 20/64

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 October 2020
Agenda Reference:	Item No: 7c
Sponsoring Director:	Chief Executive
Author(s):	Board Secretary
Title of Report:	TSH Response to Covid 19 Global Pandemic – Update
Purpose of Report:	For Discussion

1 SITUATION

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

The Board has previously received reports at its meetings in April, June and August 2020 to set out the actions taken to meet the twin aims of health protection and prevention of spread.

The Board reviewed the finalised TSH Interim Remobilisation Plan (for the period to August 2020) at its meeting on 2 July 2020.

The Board has also had sight of the draft TSH Remobilisation Plan (for September 2020 to 31 March 2021) which sets out a detailed plan for remobilisation of the hospital during this timeframe. It is confirmed that the draft document was submitted to Scottish Government by the due date of 7 August 2020.

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 the Covid-19 outbreak, since the date of the last Board meeting.

Senior Leadership and Management Structure

Since its inception on 16 March 2020, the Board has received detailed reporting on the establishment of an Incident Command Structure in accordance with the resilience framework

of TSH to ensure that TSH, as part of NHS Scotland, has had emergency preparedness in place to plan for and respond to a major incident.

On 4 May, Silver Command reduced its frequency of meetings to three times a week, with a newly constituted Hospital Huddle meeting on the other four days. On 5 August, Gold Command agreed that Silver Command could reduce to two meetings a week, with the Hospital Huddle meeting on the other three weekdays and once each weekend. A debrief session was held on 7 August to review the effectiveness of the incident command structure, and to identify areas of learning.

As part of the TSH Remobilisation Plan for the period to 31 March 2020, it was agreed that the Incident Command Structure would be stood down, and a planned shift made to a new management structure. However, there is continued recognition that the risk that Coronavirus (Covid-19) could present to the TSH primary aim, to provide high quality, effective care and treatment and maintain a safe and secure environment for patients and staff, continues to be graded as a very high risk. This will continue to be monitored closely through the Corporate Management Team. Silver and Gold Command meetings can be stood up for additional meetings should there be any urgent or significant change to the global or national position which may impact specifically on TSH.

The Covid Support Team continues to support the senior leadership team, with dedicated advice from infection control, risk management, operational management and human resources.

The Board has received detailed reporting on the process of reviewing and implementing national guidance from UK Government, Scottish Government and Professional Bodies. This continues to be tracked by the Covid Support Team, and reviewed through the Scientific and Technical Advisory Group (STAG) which will report to the Corporate Management Team.

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 Interim Clinical and Support Services Operational Policy

Version 15 of the Interim Clinical Operational Policy was published on 17 September 2020. This saw changes to activities being offered to patients, and a further easing of restrictions on a COVID secure basis.

In summary, up to eight patients can now access the dayroom, and access to the hub dining rooms has been re-introduced. Access to the Skye Centre has been increased with the sports hall, patient learning centre, and the gardens all open. It is important to underline that patients access these services on a separate ward by ward basis. The use of outdoor gym equipment was also re-introduced.

The Interim Clinical Operational Policy remains subject to regular scrutiny and review. This is underpinned by daily data gathering and reporting, and a formal weekly review meeting. This results in a recommendation to the Corporate Management Team (or Gold Command if stood up) regarding continuation and/or adjustment to the Policy.

Monitoring is focused on a range of key areas of data including clinical incidents, observation levels, patient feedback and participation in purposeful activity.

There are no concerns in relation to the data that is reported with regard to the wellbeing of our patients, and overall access to, and participation in, activities remains at a good level, with around 1000 pieces of recorded activity per week.

The Mental Welfare Commission receives weekly reports, which adds an important additional element of scrutiny. The Commission will publish a report on 21 October 2020, in relation to their first visit to TSH since the onset of Covid-19, on 18 August 2020. The Commission noted a particular interest in: the effect of Covid-19 on patient care, the effect of additional restrictions, contact with carers and families, patient activity levels and access to outdoor space, and impact on the mental health of patients.

The visit was to Iona and Lewis Hubs, and the published report is very positive. It highlights the great efforts which have been made to ensure that patients have been well engaged during the COVID-19 period. There were no recommendations made for improvement.

3.2 Infection Control

A strong focus on infection prevention and control remains central to the response to Covid-19 within TSH. The Board is aware that the Senior Nurse for Infection Control is part of the internal Covid-19 response team and receives external support from the Public Health team in NHS Lanarkshire.

The Board has received regular reporting on the implementation of additional measures to mitigate the risk of nosocomial infection at TSH. All changes to practice are reviewed by the Scientific and Technical Advisory Group. The Infection Control Committee restarted in July 2020, and is now meeting regularly.

Since the date of the last Board meeting, there have no new confirmed cases of Covid-19 within the patient population in TSH. Overall since 17 March 2020, 58 patients have been tested with 8 positive cases confirmed all of whom have recovered without medical intervention.

Table 1: Number of Patient tests, positive and negative results.

Month	Mar	April	May	June	July	Aug	Sept	Oct	Total
Total Tests	13	6	3	5	17	4	7	3	58
Asymptomatic tests	0	0	1	5	14	2	6	1	29
Positive results	8	0	0	0	0	0	0	0	8
Negative results	5	6	3	5	17	4	7	4	50

To date, 157 members of staff have been tested for Covid-19, representing 24% of the total staff population, and 2% positivity rate.

Table 2: State Hospital Staff tests by result, and as percentage of total staff population

	Number	% of Total Staff population (n=650)
Staff tests	157	24%
Positive test results	13	2%
Negative test results	143	22%

3.3 Test and Protect

The Board has received detailed reporting in respect to the approach to Test and Protect at TSH which is in alignment with the current national position.

TSH is compliant with national guidance issued 26 June – Covid-19: Pre-testing of New Admissions to the Secure Estate.

TSH is also compliant with national guidance in relation to staff testing with confirmation from Scottish Government that forensic psychiatry does not fall within the definition of long-stay mental health as defined in this guidance. The approach remains under review and is in alignment to national guidance. Testing is provided through NHS Lanarkshire, and an internal tracing programme is in place and has been subject to a desk top review exercise.

3.4 Clinical Care Guidance for COVID -19 patients

The Board has previously received reporting on the Covid-19 TSH Clinical Care Support Documentation which was developed to assist in the care of patients who have Covid-19 within The State Hospital**.** A six bed General Medical ward was established in Mull Hub which remains equipped and ready to accept any patient who requires enhanced care for symptoms of Covid-19. It has not been necessary to use this facility to date, but it remains in situ with TSH, and on stand-by as a precautionary measure.

3.5 Personal Protective Equipment

The State Hospital continues to be linked with National Services Scotland (NSS) through procurement. National stockpile supplies have been received by the hospital for Personal Protective Equipment (PPE). To date, there have been no issues with stock availability on site. Escalation routes remain available through the TSH Single Point of Contact (SPOC), the Director of Security, Estates and Facilities, and through NSS Covid-19 Supplies Portal. Usage and supplies are monitored daily.

3.6 Patient Flow

During the Covid-19 pandemic and given the necessary focus on infection control, patient flow across the forensic estate decreased. As part of the wider forensic network, The State Hospital has taken part in collaborative work with medium and low security care providers, and in conjunction with Scottish Government Mental Health Directorate, focussed on the challenge of Covid-19, and separate from the Independent review of Forensic Mental Health. This includes admission to, and transfer between, secure mental health services, suspension of detention and preparation for moving into the community.

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

Table 3: Patient flow 1 August to 30 September

	MMI	LD	Total
Bed Complement	128	12	140
Staffed Beds	108	12	120
Admissions	4	0	4
Discharges / Transfers	4	0	4
Average Bed Occupancy: Available beds/All beds			94.2% / 80.7%

3.7 Virtual and In Person Visiting

In line with national guidance, in person visiting re-commenced in TSH in the week beginning 13 July 2020 for single named visiting contacts. The family centre was re-designated for this purpose allowing for physical distancing and appropriate infection control measures to be put in place. A protocol was been developed and agreed by Gold Command to enable in person visits to take place within wards for patients who require high supervision or high support, to facilitate visiting for these patient cohorts.

However, in person visiting was paused on 11 September 2020, following the initial local restrictions put in place in South Lanarkshire local authority area followed by national restrictions.

Video-visiting was introduced in TSH in April 2020, enabling patients and their families and carers to continue to connect. This is a new and innovative service within a high secure setting, and has been security assessed to ensure compliance with legal restrictions orders. The service has been extended to professional visitors e.g. legal representatives. This service continues to provide essential contacts for patients and their carers especially in the absence of in person visiting. A detailed evaluation exercise is underway to ensure we fully understand the video visiting experience, and to identify areas for improvement.

3.8 Workforce

3.8.1 Attendance Management

The Board has received an update on attendance management at each Board meeting as part of reporting on the response to Covid -19. The Board will now receive dedicated reporting in this area, including Covid-19 related absence.

3.8.2 Planning for Extreme Loss of Staff

The Extreme Loss of Staff Plan was developed in response to a significant threat to business continuity as a result of the coronavirus pandemic. A level 2 resilience exercise was held on 18 May 2020 which stress tested The State Hospital's Extreme Loss of Staff Plan, and provided assurance on preparedness at a local level.

3.8.3 Staff Recruitment

In line with national directives and the loss of staff plan, recruitment of nursing staff has been a priority.

There have been twelve Staff Nurse appointments made from the current pool of Final Year Student Nurses who have been completing the last six months of their education in clinical practice since April 2020, working directly as part of ward teams. Eleven out of the twelve now have all necessary pre-employment checks and are now in post as Staff Nurses. There are also eight vacant Charge Nurse positions presently at interview stage.

Furthermore, 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 37 posts (including the above mentioned eight Charge Nurse posts) actively moving through the recruitment process.

3.8.4 Staff Wellbeing

Staff Wellbeing is now led through the Human Resources directorate. The Board received detailed reporting in June 2020 in respect of the tiered model which has been adopted locally to support employee health and wellbeing throughout the pandemic. The Professional Nurse Advisor is the nominated Wellbeing Champion and is coordinating this initiative.

The Staff Wellbeing zone continues to be well used, with staff deriving great benefit from this service. The zone was initially set up within the Islay Training Centre and, following an accommodation review, will move to a permanent site in Harris as of November 2020.

The Board is aware that TSH has received charitable donations during the pandemic, and a steering group was formed within TSH with oversight of spending. To date, monies have been invested in purchase of Nintendo Switches for all wards – this being equipment considered supportive of a positive atmosphere for both patients and the staff working in support. In addition, massage equipment was purchased and sited within hub areas for staff use. This is in addition to the 'relaxation station' sited within the Staff Wellbeing Zone. Presently, it is planned that residual funds will be spent on resources for the Staff Wellbeing Zone.

TSH implemented the national Everyone Matters Pulse Survey during September 2020, as the Staff Experience Measurement for 2020, giving staff an opportunity to express their views. The output from this survey will assist TSH in continuing to take an informed approach to staff health and wellbeing, workplace culture, as well as the wider equality and diversity agenda.

3.8.5 Personal Development Planning and Review (PDPR) compliance

In line with national targets, a key priority within the State Hospital's Staff Governance Action Plan is to ensure that all staff have an annual KSF personal development planning and review meeting with their line manager.

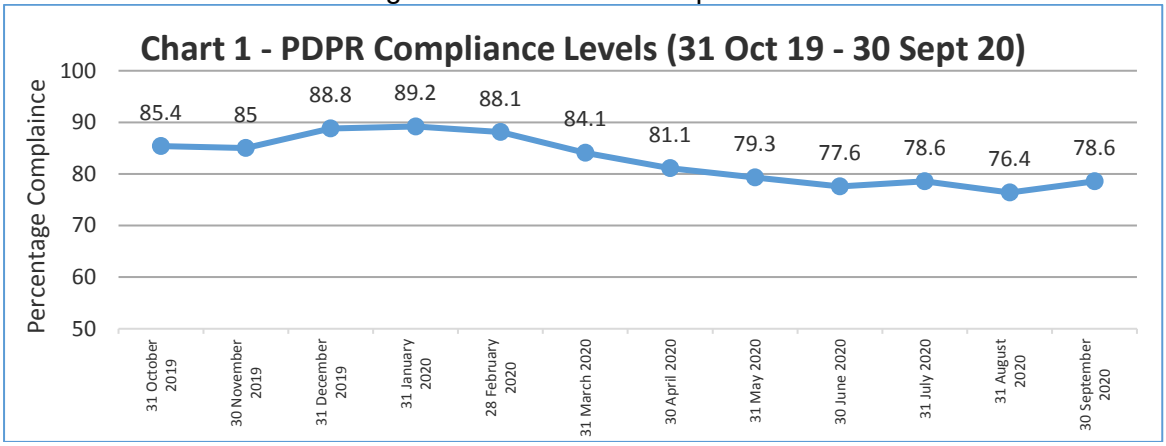
NHS Boards were instructed in DL (2020)/5 Coronavirus (Covid-19): National Arrangements for NHS Scotland Staff, issued on 13 March 2020, to postpone all non-urgent business, including appraisals. As part of the remobilisation agenda, managers are being encouraged to resume the PDPR process and to make arrangements to complete the overdue and forthcoming reviews. National guidance is awaited, however, within TSH many departments have restarted the process and are progressing completion of annual reviews. This is a

positive development given the role and potential contribution of the review discussion in relation to staff wellbeing and staff support.

As at 30 September 2020:

- The **total number of current (i.e. live) reviews was 485 (78.6%)**.
- A total of 104 staff (16.9%) had an out-of-date PDPR (i.e. the annual review meeting is overdue).
- A further 28 staff (4.5%) 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 over the last 12 months.



3.9 Recovery and Innovation

The Recovery and Innovation Group will continue to report through the Corporate Management Team to help inform and support remobilisation planning. This work will continue during the phased remobilisation of TSH helping to support strategic planning.

The Recovery and Innovation Group has received and discussed feedback from staff, patients, carers and volunteers, and the Board received detailed reporting in this regard at its meeting on 27 August 2020.

The group will report to the Corporate Management Team on the implementation of the associated activities form the Royal Society for Arts framework and the Remobilisation Plan and position these developments. A programme of work, from the engagement activities has been reviewed with associated Executive Directors appointed as leads for key themes emerging, and a RAG (red, amber and green) status has been assigned to indicate the level of progress with each activity.

The Board should notes that these themes have also been matched against the main themes of the Sturrock Review as well as areas of relevant learning for TSH from the Strang Report in to Mental Health Services in NHS Tayside.

Engagement of staff and teams at all levels throughout the organisation is key to making change happen and will ensure that the organisation can be in a stronger position to implement

the feedback and learning from this challenging period. Quality Improvement approaches and methods will be used where possible, empowering staff throughout the organisation to actively design, test and implement changes.

Further reporting will be brought to the Board Seminar on 4 November, as well as to the Staff Governance Committee for their oversight.

3.10 Communication

Throughout the Covid-19 pandemic, communication of information and decisions from incident command were shared through staff bulletins. These have included any national updates together with TSH specific information. Covid-19 Bulletins continue to be issued twice weekly, and this is linked to the responsibility of Directors and Heads of Department to ensure that their teams are briefed regularly on key developments.

3.11 Digital Technology

Digital transformation has been a key area of focus during Covid-19, with significant gains having been made within TSH during the Covid-19 pandemic. In particular, patients have been supported in maintaining virtual visiting contact with families and carers. In addition, staff have been supported to transition to remote and flexible working patterns whenever possible.

The Board workplan included annual reporting for eHealth at the August Board Meeting. This report has been deferred due to the impact of Covid-19, with detailed reporting being presented to the Board through the Covid-19 Remobilisation Plan for September 2020 to March 2021. This is a key area of focus for TSH over the course of the next six months to build on the progress already made.

4 RECOMMENDATION

The Board is invited to:

1. Review and discuss 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. Endorse this position as an appropriate framework for continued operational management and governance during the Covid-19 pandemic.

3. Outline any additional reporting requirements.

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
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
Equality Impact Assessment	Not required for 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).	There are no identified impacts.
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One X There are no privacy implications. □ There are privacy implications, but full DPIA not needed □ There are privacy implications , full DPIA included.

THE STATE HOSPITAL BOARD FOR SCOTLAND

Date of Meeting:	22 October 2020
Agenda Item:	Item No. 7d
Sponsoring Director:	Director of Finance and Performance Management
Author(s):	Director of Finance and Performance Management
Title of Report:	Financial Update – Covid-19
Purpose of Report:	For Noting

1 SITUATION

Due to the Covid-19 crisis, additional specific costs are now 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 have been formally reported on a regular basis, since March, to the Scottish Government's Covid-19 Health Finance team within the Health Finance and Infrastructure Directorate. Feedback / discussion has followed directly on each of these reports, including a focus on consistency of reporting between boards.

The most recent report – for the three-month period April-June (Q1) – was submitted mid-August, incorporating a forecast of expected costs for the remainder of the financial year.

The Q1 reports for all boards were collated nationally, with a review to assess the overall NHSScotland position and what proportion of individual board costs were to be reimbursed as additional in-year allocation. The outcome of this review was expected mid-late September and the State Hospital's allocation was in fact notified on 1 October, as noted below in 3.1 and 3.2.

The next stage of SG review will be that of the report for the Q2 period (to 30 September) – the submission of which is due in late October. From this next review, any updated allocations (subject to additional SG funding) are expected to be notified in January 2021.

3 ASSESSMENT

3.1 Financial Governance and SG allocation

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

For the Q1 return for April-June, including forecast costs for the remainder of the year, the revenue costs as noted in paragraph 3.2 below were specified in the Hospital's Covid19 returns – totalling approx. £2.1m.

While initial indications from SG were that all Boards' Covid-related costs would be reimbursed in full, it became clear during Q2 that this would not be affordable for SG, and the actual position now confirmed as an additional allocation is that TSH are receiving approx. £1.6m for 2020/21.

As the exact calculation methodology for this allocation is awaiting confirmation, it is understood that the approximate basis used by SG (for all National Boards) was to cover 100% of costs incurred in Q1 plus a percentage – understood to be around 70% - of forecast costs for Q2-4. It is these forecast costs, and the allocation thereto, which will now be monitored in the next quarters' returns, from which there could remain the possibility of allocation revisions.

In the meantime, we are apportioning the receipt of the additional allocation against our costs for Q1 and Q2 on the above basis, and will factor that same apportionment into the forecast costs for Q3 and Q4.

3.2 **Covid19 costs**

The principal revenue costs incurred in relation to Covid19 in April-June 2020, and forecast for July 2020-March 2021, as submitted in the Board's Q1 return are as undernoted.

i – Overtime costs Q1 £290k, forecast Q2-4 £800k – 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.

ii – Nursing recruitment Q1 £130k, Q2-4 £130k – being an additional 12 student nurses on 6-month contracts. While this was initially understood to be funded by NES as part of a national initiative to support Covid pressures, this did not materialise and it was then to be regarded as provided directly through the Covid funding.

iii – Additional deep cleaning Q1 £5k, Q2-4 £12k – being extra cleaning requirements specific to rooms for patients with positive Covid test results.

iv – Telephony, related IT and digital costs Q1 £18k, Q2-4 £54k – being the costs of teleconferencing and other remote communication costs now being incurred.

iv – Estates/facilities costs Q1 £12k, Q2-4 £9k – including the requirement for additional lockers, trolleys, chairs etc.

v – "dual running" staff costs – forecast Q2-4 £260k.
We have incurred the costs of the Covid-19 support team (Q1 £105k, forecast Q2-4 £315k) – having in March established a specific team to provide support to the management of the Covid-19 crisis, comprising 9 members of staff seconded from various departments where their normal workload either stalled or was being undertaken by others in the team, with no backfill in place. Being staff seconded in this manner, these costs are viewed in Q1 and Q2 as supported from within budget.
However, the Hospital is now taking forward new staffing posts which are resulting from the ongoing crisis and the recommencing of areas of work while – at the same time – maintaining this Covid support team – the "dual running" costs of these posts is now recognised in the forecast.

vi – IT costs Q1 £20k, Q2-4 £20k – additional equipment (laptops, mobile phones, licences etc.) necessary in order to facilitate remote working for a number of staff and other essential IT site requirements.

vii – Other equipment costs Q1 £14k – including new monitors, some pandemic PPE stock, uniforms, and patient tvs/radios.

viii – Perimeter project contingent costs Q2-4 £250k – this was included in our forecast costs to cover the contingent risk of any project delay or contractor access delay arising from staff being unable to access TSH site due to Covid – cost estimate being based on potential daily delay costs which could arise.

4 RECOMMENDATION

The Board is asked to note this report.

Author:
Robin McNaught
Director of Finance and Performance Management
01555 842004

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 financial implications – for information only
Route to SG/Board/SMT/Partnership Forum Which groups were involved in contributing to the paper and recommendations.	Board requested – from Finance and Performance Management 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.

Board Report 20/66

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 October 2020
Agenda Reference:	Item No: 8
Sponsoring Director:	Director of Nursing and Allied Health Professions
Author(s):	Person Centred Improvement Lead
Title of Report:	Person Centred Improvement Service Twelve Month Board Report 2019/20
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 2019 to October 2020 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, 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

- 9 of 14 outcome measures have been achieved.
- 3 of those partially achieved are directly as a result of the impact of Covid-19.
- 1 outcome relates to wider service change. It is anticipated that this measure will be complete by April 2021.

The report highlights key achievements including:

- Supported patient engagement in TSH3030.
- Implemented 'hire purchase scheme' to provide patient TV/ Radios.
- Initiated plan to introduce electronic Grounds Access Applications.
- Informed review of process relating to withdrawal of patient newspapers.
- Implemented patient clothing donations scheme.
- Introduced tailored format of PPG for Intellectual Disability patients.
- Developed and implemented interim visiting process (Covid-19).
- Contributed to introduction of centralised visit booking system.
- Produced weekly Covid-19 Patient Update.

Actions for the next twelve months including:

- Tailor national 'Interpretation and Translation Policy' for implementation locally.
- Develop Carers' Policy.
- Adapt local Volunteer Impact Assessment to incorporate national volunteering framework.
- Support Hospital wide working group to identify and explore options to develop an enhanced visiting experience aligned to the refreshed Clinical Service Delivery Model.
- Undertake QI project to increase the number of patients receiving visits.
- Publish Equality Outcome Report to national standards.
- Support progression of the digital agenda to enhance patient and carer involvement.
- Undertake service review to support service remobilisation and new visiting model.
- Support Hospital-wide Patient Activity project.

4 RECOMMENDATION

The Board is invited to*:*

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

Author:
Sandie Dickson
Person Centred Improvement Lead
01555 842072

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives?	Supports delivery of the Person Centred Improvement Service Delivery Plan and person-centred deliverables within TSH Annual Operating Plan.
Workforce Implications	None
Financial Implications	None
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 Community Engagement
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	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	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 2019 - OCTOBER 2020

Contents **Page**

1. Introduction

The 'Person Centred Improvement Service' (PCIS) supports services across The State Hospital (TSH) through its diverse work streams contributing to achievement of the local Annual Operating Plan (2019) 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 Patient Advocacy Service (PAS).

TSH Person Centred Delivery Plan (2018-21) 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 (ref 2)).

This report relates to the period November 2019 to October 2020, 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) and 'Excellence in Care' (Scottish Government, 2015) (ref 4), which make explicit the need to ensure that stakeholder feedback is embedded within service design.

As a result of the impact of Covid-19, less than five months of the reporting period is directly relevant to the service objectives agreed in the autumn of 2019. The report therefore also includes an overview of the contribution of the PCIS to supporting patients to adapt to changes manifesting through the interim clinical service delivery model.

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:

- Mental Health Strategy (2017-2027) (ref 5).
- Health and Social Care Delivery Plan (2016) (ref 6).
- 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).
- British Sign Language (BSL) National Plan (2017-2023) (ref 10).
- Equality Act (2010) (Specific Duties) (Scotland) (ref 11).
- Patient Rights (Scotland) Act (2011, updated 2019) (ref 12).
- Carers (Scotland) Act (2016) (ref 13).
- Fairer Scotland Duty (2018) (ref 14).
- Volunteering for All: Our National Framework (2019) (ref 15)

Partnership working continues with key external stakeholder groups, including the Scottish Government Person Centred Stakeholder Group, Mental Welfare Commission, Health Improvement Scotland Community Engagement (HISCE), Health Improvement Scotland, Scottish Human Rights Commission, 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 and Allied Health Professions, 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 support local practice relating to the above portfolio. The patient Chair of the Patient Partnership Group (PPG), members of the Carers' Forum and Volunteer Service Group are included within the core membership, in addition to a representative from HISCE and the Patient Advocacy Service (PAS).

The group discuss a wide range of quarterly monitoring reports including:

- Patient and Visitor Experience.
- Volunteering input.
- Spiritual and Pastoral Care input.
- Progress to TSH Equality Outcomes (2017-21).
- Progress to TSH British Sign Language (BSL) Action Plan (2018-24).
- Advocacy input.
- Protected Characteristic groups equality monitoring
- Learning from Complaints and Feedback.
- Person Centred 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 Clinical Governance Group (CGG) and Clinical Governance Committee (CGC).

3. Key pieces of work undertaken

- Supported patient engagement in TSH3030.
- Implemented 'hire purchase scheme' to provide patient TV/ Radios.
- Initiated plan to introduce electronic Grounds Access Applications.
- Informed review of process relating to withdrawal of patient newspapers.
- Implemented patient clothing donations scheme.
- Introduced tailored format of PPG for Intellectual Disability patients.
- Developed and implemented interim visiting process (Covid-19).
- Contributed to introduction of centralised visit booking system.
- Introduced Iona 2 tailored PPG.
- Produced weekly Covid-19 Patient Update.

4. Wider input

TSH Strategic Objectives
"Create conditions for supporting quality assurance, quality improvement and change".

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 improvement initiatives including, however not limited to:

- TSH 3030 initiative.
- Health inequalities.
- Carer engagement in the Care Programme Approach (CPA) process.
- Supporting patients' physical health.
- Visiting experience.
- Patient digital inclusion.

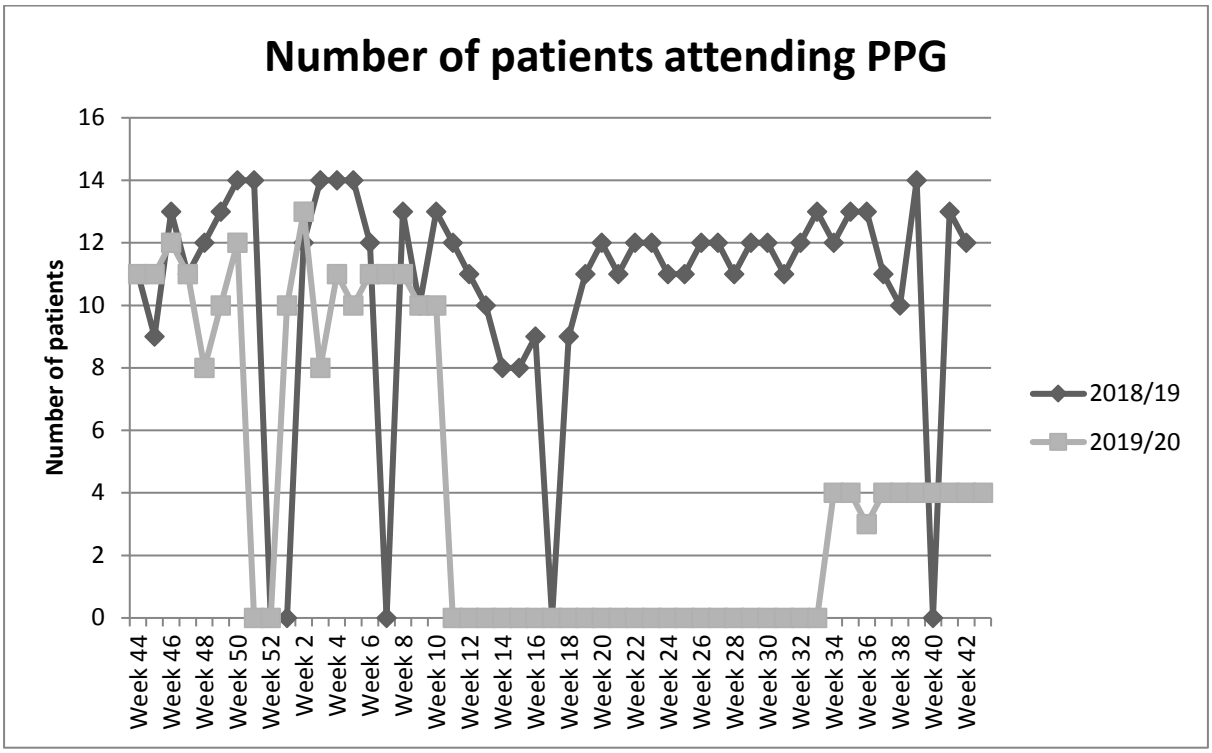
These skills are also used to support external QI projects including:

- Assessing the impact of volunteering.
- Review of NHS Spiritual and Pastoral Care standards.
- NHS Interpretation and Translation Processes.

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. b) PPG membership includes representation from all hubs. 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 5 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) 12 of total of 18 indicators achieved
5.	Carers are enabled to contribute meaningfully to patient outcomes.	a) Undertake cycle 3 Triangle of Care assessment (ref 17). b) 'Green' level achieved for 65% of indicators.
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. *b)* 10% increase in quality compliance scores when compared to 2019.
7.	Progress to achieving the three published TSH Equality Outcomes by April 2021.	a) Outcome 1*:* All patients within The State Hospital are advised of their right to have a Named Person, who is informed of the responsibilities of this role. b) Outcome 2*:* Healthy lifestyle plans are in place, which engage patients, carers and staff in supporting a holistic approach to physical health and wellbeing, contributing to patient weight loss. c) Outcome 3: Individual patient Care and Treatment Plans are explicit in terms of identifying and making provision for needs which may impact on a patient's ability to meaningfully engage in care and treatment processes and contribute to the review of progress.

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



a) PPG facilitated 50 weeks
(target of less than 52 weeks, accounts for 2 public holidays).

Delivery to outcome measure a): Partially achieved.

Weeks 51 & 52: (public holidays) – planned closures
Week 11-32: (unable to meet as a group due to Covid-19)
Week 33 onwards, PPG Iona 2 members sub-group
Facilitated 24 weeks. PPG suspended mid-March 2020 as a result of Covid-19 restrictions.

b) PPG membership includes representation from all 4 hubs

Delivery to outcome measure b): Achieved.

100% of hubs 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

Delivery to outcome measure c): Achieved.

(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). Attendance at meetings fluctuates depending on the meeting agenda, mental health presentation of group members and requirement to attend tribunals and external clinical appointments which cannot be scheduled around the group timetable. The average attendance was 10 patients.

PPG patient Chair asked to reflect on the challenges of undertaking this role since suspension of PPG, due to Covid-19:

"I didn't have grounds access until a couple of months after lockdown so it was impossible for me to hear about how patients in other wards were doing before then. We were spending most of the time in our own rooms so there wasn't much time to check-in with the guys in the day room. Since I've had Grounds Access, I can speak to patients I meet when I'm out for a walk. But some patients who need to be escorted might not want to speak to me in front of staff and we're told not to stop to talk. I used to speak to other patients when I was in the Skye Centre for placements and having a coffee, but this opportunity was also not possible. New admissions won't know who I am and what my role is. Instead of sharing patients' views face to face at the Person Centred Improvement Steering Group, I'm doing this via a teleconferencing call which is not as good as seeing people in person. I understand the Hospital has a group looking at how patients can communicate using technology – this would have been helpful throughout lockdown and even now when wards can't mix."

PPG Chair, September 2020

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

Delivery to outcome measure d:) Achieved.

In addition to input from Catering staff, Community Engagement, and PAS, other stakeholders have engaged directly with PPG during the year, including, however not limited to: Board Chair, Director of Nursing and AHP and University of Edinburgh Research Assistant. The curtailed operational period impacted on the planned timetable of engagement.

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

a) Recruit and train 5 new volunteer visitors

Delivery to outcome measure a): Partially achieved.

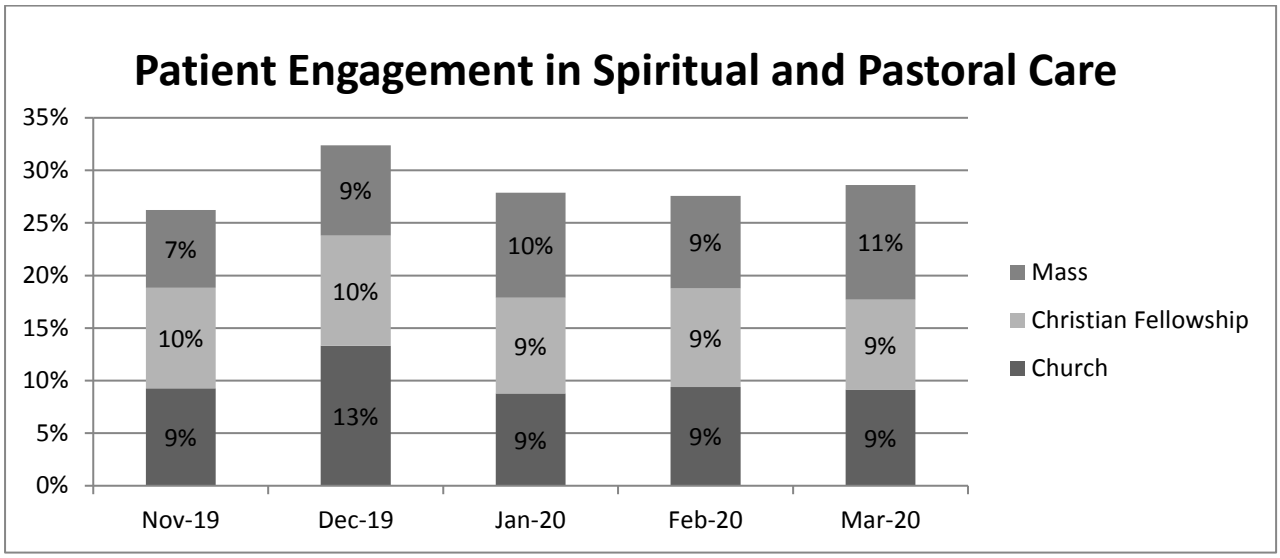
Three volunteer visitors recruited, trained and in place. Volunteer recruitment suspended mid-March 2020 due to Covid-19 restrictions.

3) Wider patient attendance at group based spiritual & pastoral care activities

a) Attendance mirrors national average trend (8.9%)

Delivery to outcome measure a): Achieved.

Increased engagement in December as a result of ad hoc attendance of Ecumenical Service. This mirrors national trends.



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

a) 12 of total of 18 indicators achieved

Delivery to outcome measure a): Achieved.
Actions to support completion of 14 indicators complete. One of the outstanding actions is impacted by lack of progress at a national level. Remaining 3 indicators on target for completion by 2022.

5) Carers are enabled to contribute meaningfully to patient outcomes

a) Undertake Cycle 3 Triangle of Care assessment (39 indicators)

Delivery to outcome measure a): Achieved.

b) 'Green' level achieved for 65% of indicators

Delivery to outcome measure b): Achieved.

69% = 27 indicators

Standard	Red	Amber	Green	Total No. of Indicators
No. 1	2 (2)	2 (3)	4 (3)	8
No. 2	1 (1)	1 (1)	1 (1)	3
No. 3	2 (2)	1 (2)	5 (4)	8
No. 4	0 (1)	1 (2)	4 (2)	5
No. 5	2 (3)	0 (3)	10 (6)	12
No. 6	0 (3)	0 (1)	3 (2)	*3 (6)
Total	**7 (12) -5**	**5 (12) -7**	**27 (18) +13**	**39 (41)**

Figures in brackets relate to outcome of 2nd cycle
**3 indicators merged following consultation with Carers Trust (Scotland)*

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

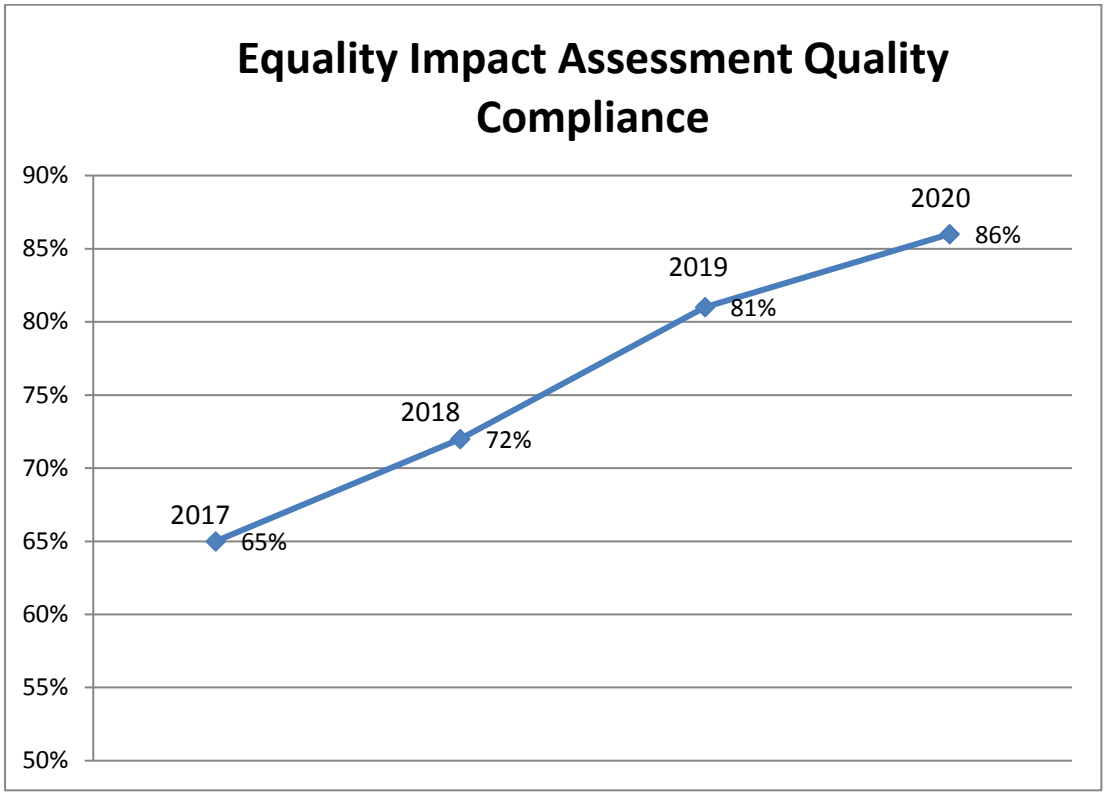
Delivery to outcome measure a): Partially achieved.

Work on refreshing local policies was suspended in mid-March 2020 as a result of the need to focus on adapting critical areas of service delivery in response to the impact of Covid-19. This had a direct impact on the timetable of policy reviews.

b) 10% increase in quality compliance scores when compared to 2019

Delivery to outcome measure b): Partially achieved.

5% increase in quality compliance achieved.



TSH currently has a suite of 122 policies, 38 of which have not yet undergone the local EQIA process. 14 are owned by Human Resources, relating to 'Once for Scotland' policies, which should not require a local EQIA. The remainder are all flagged within the policy management process.

The data continues to indicate room for improvement in relation to the impact of policies / protocols, specifically in the context of the Protected Characteristic groups**.** The characteristics relating to 'disability', 'age' and 'race' are of particular relevance to the organisation in the context of future-proofing clinical service delivery and should be used to inform work streams relating to the configuration of clinical services moving forward.

1:1 input is being provided to support policy authors to consider this area of policy development to ensure a proactive approach to mitigating potential health inequalities

3) Progress to achieving the three published TSH Equality Outcomes by April 2021

a) Equality Outcome No. 1 Aim: The State Hospital will ensure the needs of vulnerable patients with a mental health diagnosis are protected by embedding implementation of section 22 of the Mental Health (Scotland) Act, 2015.

Objective: All patients within The State Hospital are advised of their right to have a Named Person, who is informed of the responsibilities of this role.

Delivery to outcome measure a): Achieved.

b) Equality Outcome No. 2 Aim: The State Hospital will implement individually tailored healthy lifestyle plans which support the physical health and well-being of all patients within the Hospital.

Objective: Healthy lifestyle plans are in place, which engage patients, carers and staff in supporting a holistic approach to physical health and wellbeing, contributing to patient weight loss.

Delivery to outcome measure b): Achieved.

c) Equality Outcome No 3 Aim: Service delivery will enable all patients within the Hospital to benefit from equitable access to care and treatment:

Objective: Individual patient Care and Treatment Plans are explicit in terms of identifying and making provision for needs which may impact on a patient's ability to meaningfully engage in care and treatment processes and contribute to the review of progress.

Delivery to outcome measure b): Partially achieved.

8 of 9 indicators complete. Remaining action transferred to Mental Health Practice Steering Group as a priority for completion, in collaboration with wider changes relating to the Clinical Service Delivery Model.

Key performance indicator overall performance
9 of 14 outcome measures achieved. 3 of those partially achieved are directly as a result of the impact of Covid-19. 1 relates to wider service change. It is anticipated that this measure will be complete by April 2021.

6. Wider service specific performance objectives

Delivery of Mandatory Equality and Diversity Training
This area of our training suite continues to be delivered via the mandatory online module, in addition to attendance at a half day interactive workshop. 100% of planned sessions were delivered prior to suspension of physical training as a result of Covid-19 restrictions.

Enabling Patients to share Feedback which Contributes to Service Design

The national 'What Matters to You?' initiative was not facilitated this year due to Covid-19. However, the PCIS have proactively, throughout the Covid-19 trajectory, engaged with patients with a view to understanding what matters to them specifically in relation to changes to the care delivery model introduced to mitigate the risk of infection.

A range of methods have been employed to ensure that all patients are able to share their views including, however not limited to:

- 'Walk and Talk' with the PCIL and CEO.
- Graffiti Wall (appendix 1).
- Structured feedback pro-forma.
- Iona 2 'emoji' stories (appendix 2).
- Emotional Touchpoints.
- Creative writing.

With restrictions on the mixing of patients from different wards, PPG has been unable to meet as a group since mid-March 2020. In order to ensure that members continue to be supported to share their views and contribute to changes to the service delivery model, the PCIT have adopted a 1:1 ward outreach approach to ensure feedback is elicited, captured, recorded and disseminated. The PPG Patient Chair meets weekly with members of the PCIT having a pivotal role in eliciting views from peers where the opportunity arises.

Patient feedback is currently shared with senior managers and operational leads via the PCIL as a member of Silver Command. This approach supports a rapid response to patient and carer feedback, which informs ongoing iterative changes to operational protocols driving service recovery. There is a clear correlation between stakeholder feedback and decisions made to reintroduce services, following robust risk assessment, which are important to patients. There are many examples of the 'you said, we did' model, including:

- Access to activity (including outdoors).
- Weekend and evening activity.
- Access to the Hospital Shop.
- Access to the grounds.
- Use of external gyms.
- Remote access to the Hospital library.
- Video and physical visiting.
- Access to televisions / radios in bedrooms.
- Weekly themed meal.
- Access to hair clippers prior to resuming hairdressing services.
- Access to fresh fruit.
- Access to emergency clothing (appendix 3)

As a member of a number of internal groups, the PCIL ensures the views of stakeholders are shared within discussions informing service design:

- Senior Management Team (SMT).
- Clinical Governance Group.
- Skye Centre Leadership Team.
- Patient Active Day Project Group.
- Mental Health Practice Steering Group.
- Clinical Forum.
- QI Forum.
- Security Governance Group.
- Service change consultation / Short Life Working Groups.

The PCIL also 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.
- NHS/Third Sector Volunteer Leads.
- Scottish Government Cross-Party Volunteering Forum.
- NHS Spiritual and Pastoral Care Leads.

<u>Volunteer Input</u>

There are currently 15 volunteers (17 in 2019) providing a wide range of input to complement service delivery across the Hospital. In response to Stakeholder feedback volunteer recruitment is now a targeted approach in collaboration with services who are encouraged to identify specific roles which compliment gaps in patient activity. This practice supports a mutually beneficial outcome in terms of ensuring volunteers have the skills/interests required for the area in which they are placed.

Priority recruitment of volunteer visitors continues to be a focus to meet gaps identified in terms of the number of patients who receive no visits. Despite having almost 450 approved visitors, many do not visit and a large number visit irregularly. The need to understand more about this trend has been identified as a key action for the coming year.

Carer Support

Throughout this challenging period, the Person Centred Improvement Advisor has been in regular contact with a significant number of carers, many of whom were shielding/self-isolating and had little contact with others. Carers welcome this approach and continue to shared positive feedback about the way in which the Hospital is managing the risks of infection.

Visiting commenced within the Family Centre in July 2020 for patients able to tolerate off ward visiting. This centralised visiting model mirrors the approach taken by colleagues in other high secure environments. An individually tailored approach is in place to support a limited number of carers to continue to visit within the ward, where clinical presentation indicates this is preferable.

A structured feedback exercise has taken place to support ongoing development of this service, which also responds to feedback received previously in relation to visiting within the ward environment:

- Close proximity to busy clinical areas.
- No access to the outdoor environment.
- Use of dining rooms which are not conducive to a comfortable experience.
- Delays with internal transport.
- Operational ward timetabling which creates challenges around a more flexible approach to visiting times.

The Scottish Government launched the person-centred visiting experience initiative in 2019 making a commitment to implement a tailored visiting experience within all hospitals by 2020. This action was prioritised in response to stakeholder feedback which highlighted the need to consider the needs of visitors whose input is a valuable component of the patient recovery process. The interim visiting model continues to evolve, supported by the use of quality improvement methodology to inform iterative amendments to the protocol, in response to stakeholder feedback.

During this initial 5 weeks, 80 visits were facilitated involving 38 patients and their designated visitors, 30 patients and 44 visitors shared feedback about their experience:

- 73% of patients and 75% of visitors who responded prefer visits in the Family Centre.

"I really enjoyed the visit, nice and quiet atmosphere. If visiting moved to this space, then it would give us more flexibility on the times when we could have visits. This means we could go to placements as well as have a visit the same morning or afternoon".
TSH patient August 2020

"Will take some getting used to but liked it as it was quieter and more private".
TSH visitor July 2020

"If you're feeling anxious, it's better to have your visit in the ward."
TSH patient August 2020

"My mum says it's better there so I want what makes her ok about having to come here".
TSH patient July 2020

isiting out with TSH control

- No physical contact (no hugs).
- Need for visitors to wear facemasks, impacting on conversation.
- Unable to share refreshments.
- Limit of 1 visitor per visit.
- Unable to bring any items to the visit (e.g. games, books, snacks).

A scoping exercise has been undertaken to support a person-centred approach to visiting. In response to feedback received, the future visiting model is likely to offer a more flexible approach to visiting times, access to the Family Centre garden and the opportunity for visitors to have lunch with the patient.

The limited interim visiting model offers visits during the week which impacts on visitors unable to visit out with weekend days. A business case is currently being developed to inform visiting arrangements for the next 6 months, which will include weekend visiting.

Patient 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. In order to ensure continuity of input since the onset of Covid-19, the Patient Board Member has been supported to engage with the Board remotely using teleconferencing facilities.

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 monthly 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.

Progress to key actions identified within 2019 Twelve Month Service Report

	Action	Outcome	Comment
1.	Refresh of TSH Volunteering Policy.	Complete	Refreshed policy implemented.
2.	Tailor national 'Interpretation and Translation Policy' for implementation locally.	Outstanding	National policy delayed as a result of Covid-19. Awaiting intelligence regarding anticipated publication date.
3.	Develop Carers' Policy.	Outstanding	Delayed. Originally scheduled for second half of current year.
4.	Introduce 'carer link' roles in each ward.	No longer relevant	Alternative approach agreed as part of Triangle of Care work streams.
5.	Adapt local Volunteer Impact Assessment to incorporate national volunteering framework.	Outstanding	Delayed as a result of additional workload emerging from Covid-19.
6.	Develop guidance to support solution based QI approach to respond to feedback.	Complete	Updated system introduced and monitored quarterly.
7.	Spread EQIA skills.	Ongoing	5% increase in EQIA quality compliance.
8.	Provide mentoring for patients to engage meaningfully in TSH3030 projects.	Complete	89 patients engaged in the 2019 TSH3030 initiative (mentoring provided by staff across the Hospital).
9.	Support Hospital wide working group to identify and explore options to enhance the visiting experience.	Ongoing	Interim visiting model implemented. Ongoing meetings to inform improvements based on stakeholder feedback.

7. Challenges, solutions and service development opportunities

Challenges	Solutions / Development Opportunities

Competing priorities as a result of increased workload, 'flat' workforce structure, need for future proofing in terms of succession planning.	Undertake service review.
Environmental barriers – Family Centre	Develop business case, submit bids for external funding for external area.
Carer engagement aligned to supporting patients' care and treatment plans.	PCIL is a member of the Mental Health Practice Steering Group tasked with reviewing the CPA process.
Creating time to make use of specialist QI skills to support evidence approach to Hospital wide improvement projects.	Build this aspect into service review.
Implementing person-centred visiting, aligned to national guidance.	Centralised visiting area now in use. Scoping exercise to inform person-centred improvements within the limits of visiting with a high secure environment.

8. 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. A review of the service is currently underway which will inform the business case seeking to support use of the Family Centre as a permanent arrangement for patients and visitors who benefit from an off ward visiting experience.

Finance

All elements of the service were delivered within budget during the year.
With the introduction of weekend visiting and the need for staff to work public holidays, there will be an increase in costs relating to the centralised visiting model

9. Key actions for the next twelve months

	Action
1.	Tailor national 'Interpretation and Translation Policy' for implementation locally.
2.	Develop Carers' Policy.
3.	Adapt local Volunteer Impact Assessment to incorporate national volunteering framework.
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.
5.	Undertake QI project to increase the number of patients receiving visits.
6.	Publish Equality Outcome Report to national standards.
7.	Support progression of the digital agenda to enhance patient and carer involvement.
8.	Undertake service review to support service remobilisation and new visiting model.
9.	Support Hospital wide Patient Activity Project.

References

1. *Health Improvement Scotland, Health and Care Programme,* *http://www.healthcareimprovementscotland.org/our_work/person-centred_care/person-centred_collaborative.aspx*

2. *The Healthcare Quality Strategy for NHSScotland (2010)* *http://www.gov.scot/resource/doc/311667/0098354.pdf*

3. *Practicing Realistic Medicine, Chief Medical Officer's Annual Report (2018),* *https://beta.gov.scot/binaries/content/documents/govscot/publications/report/2018/04/practising-realistic-medicine/documents/00534374-pdf/00534374-pdf/govscot:document/?inline=true/*

4. *Excellence in Care- Scotland's National Approach (2015),* *https://www.gov.scot/Publications/2015/09/8281/3*

5. *Mental Health Strategy(2017-2027)* *http://www.gov.scot/Publications/2012/08/9714*

6. *Health and Social Care Delivery Plan (2016)* *http://www.gov.scot/Publications/2016/12/4275*

7. *Rights in Mind (2017)* *http://www.mwc.scot.org.uk/rights-in-mind*

8. *Safety and Protection of Patients, Staff and Volunteers in NHSScotland (2017)* *www.sehd.scot.nhs.uk/dl/DL(2017)07.pdf*

9. *Public Sector Equality Duty (2016)* *https://www.equalityhumanrights.com/public-sector-equality-duty*

10. *British Sign Language (BSL) National Plan (2017-2023)* *http://www.gov.scot/Publications/2017/10/3540*

11. *Equality Act (2010) (Specific Duties) (Scotland)* *http://www.legislation.gov.uk/sdsi/2012/97801110167181/contents*

12. *Patient Rights (Scotland) Act (2011)* *http://www.gov.scot/Topics/Health/Policy/Patients-Rights*

13. *Carers (Scotland) Act (2016)* *http://www.gov.scot?Topics/Health/Support-Social-Care/Carers/Carers-scotland-act-2016*

14. *Fairer Scotland Duty (2018)* *https://www.gov.scot/Resource/0053/00533417*

15. *Volunteering for All: Our National Framework (2019)* *http://www.gov.scot/publications/volunteering-national-framework*

16. *Christianity in the UK (2020)* *https://faithsurvey.co.uk/UK_christianity.html*

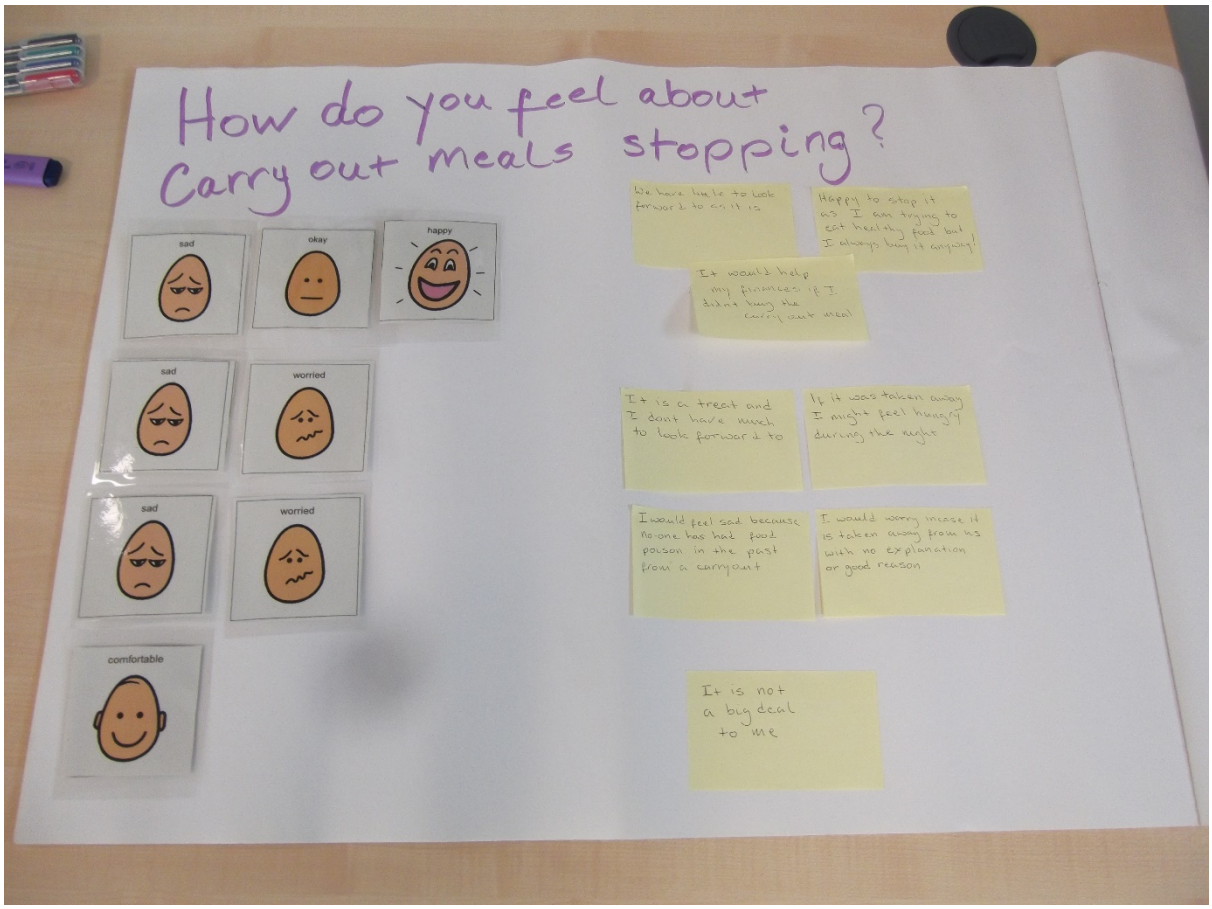
17. *Worthington A, Rooney P, Hannan R (2013) The Triangle of Care 2nd edition, Carers Trust, London*

Appendix 1 **Covid-19 Patients' Graffiti Wall: April 2020**

The word 'adapt' is the most prominent word on the 'wall' as this was the phrase used by a number of patients. They described the need for patients to be adaptable to changes to their routine as a result of the need to keep everyone safe. However, this word was also mentioned in the context of staff being adaptable to individual patient need.

Words such as 'help', 'lonely' and 'frightened' tell their own story about where patients were in the very early stages of the pandemic.

Appendix 2 Iona 2 'Emoji' Stories



"It is a treat and I don't have much to look forward to".

"If it was taken away I might feel hungry during the night."

"I would feel sad because no one has had food poisoning in the past because of a carry-out."

"I would worry in case it is taken away from us with no explanation or good reason."

"It is not a big deal to me."

"It would help my finances if I didn't buy the carry out meal."

"We have little to look forward to as it is."

"Happy to stop it as I'm trying to eat healthy food, but I always buy it anyway!"

Appendix 3 **Patient Partnership Group: Influencing Practice, Improving Experiences**

The State Hospital's Patient Partnership Group: Improving Quality of Life for Patients

You said	We did	The difference it made
"When you come in, you might not have any spare clothes cos your stuff hasn't been sent from the jail or you might have been lifted from the street. Some guys don't have any family who are going to come in and see you and you've no money." So, you go about looking like a tramp wearing the same clothes for weeks and people know you've got nothing".	Asked patients to donate any unwanted clothing, supported by the key worker (some staff also donated items). Developed a process for Clinical Teams to refer patients to the Person Centred Improvement Team who keep a limited stock of items donated to patients who need e.g. warm coats / footwear to go out for walks, jacket / shirt to attend a funeral / court.	"I enjoyed getting out for a walk much more when I got given a warm jacket". "I was going out to a family funeral and I only had t-shirts. I got a nice shirt which I can keep for other things." "My trainers had holes in them so my feet got wet when I went out. I got another pair – they're not very cool, but beggars can't be choosers."

March 2020

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 October 2020
Agenda Reference:	Item No: 9
Sponsoring Director:	Medical Director
Author(s):	PA to Medical & Associate Medical Directors
Title of Report:	Medical Appraisal and Revalidation Annul Report 2019/20
Purpose of Report:	For Noting

1 SITUATION

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

2 BACKGROUND

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

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

3 ASSESSMENT

- The Revalidation and Appraisal Committee met once in 2019-20: 4 November 2019. A meeting scheduled for 4 May 2020 did not go ahead due to Covid-19. A meeting has been arranged for 31 August 2020.

- Revalidation Policy
  The Revalidation and Appraisal Policy was approved by the Senior Management Team on 3 August 2016 and is available on the Intranet. The Policy was due for review in August 2019 and this was undertaken at the Revalidation Steering Group meeting on 7 November 2019.

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

- Revalidation System
  Revalidation system has been used for 13 Consultants and 2 speciality doctors in 2019-20. This includes one doctor on secondment to Scottish Government. One Consultant is appraised and revalidated through the Chief Medical Officer.

  Revalidation system for former / retired colleagues with honorary contracts is in place (n=1).

- Appraisals
  From 1 April 2019 to 31 March 2020, of the 13 medical staff at The State Hospital 9 were appraised during this period. 4 appraisals have been rescheduled as a result of Covid-19. The appraisal system was formally suspended by the GMC during the initial months of the COVID-19 pandemic.

- Revalidation
  One speciality doctor was revalidated during the specified period. All revalidations are up to date. Two revalidations were moved to 2021 in line with the GMC changes to the revalidation process due to COVID-19.

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

- CARE Questionnaire
  Due to the number of questionnaires patients have been asked to complete in recent months, it was agreed that these would be issued bi-annually. This is due again in August 2020 but will be postponed until November 2020 in view of COVID-19.

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

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

.

Author:
Professor Lindsay Thomson
Medical Director
01555 8424361

- Consultants	Last Date for Recommending Revalidation	Date of Revalidation	360 Degree Appraisal Date	Appraisal Date	CARE Questionnaire Return	Form 4 Completed	Appraisal 01/04/18-31/03/19	AMP Training
1	20/11/2023	31/10/2018		28/08/2020	Aug 2018		07/02/2019	2019
2	16/10/2021	17/10/2016		24/09/2019	Aug 2018	Yes	30/08/2018	2019
3	02/09/2021	03/09/2015		21/02/2019	Aug 2018	Yes	21/02/2019	2019
4	12/02/2025	04/04/20		28/01/2020		Yes	29/11/2018	2018-19
5	19/12/2024	15/11/2019		31/10/2019		Yes		2019
6	02/08/2021	02/08/2016		15/03/2019	Aug 2018	Yes	15/03/2019	2019
7	27/12/2022	27/12/2017		05/11/2019	Aug 2018	Yes	06/12/2018	2019
8	28/03/2024	11/03/2019		29/05/2020*	Aug 2018		28/02/2019	2019
9	21/12/2021	21/12/2015		12/12/2019	Aug 2018	Yes	20/12/2018	2019
10	29/07/2021	29/07/2015		21/01/2020		Yes	28/01/2019	2019
11	20/03/2025	11/12/2019		07/05/2020*	Aug 2018		25/04/2019	2018-19
Specialty Doctors								
12	16/04/25			05/12/2019				
13	29/06/2024	05/06/2019		17/07/2020		Yes	29/11/18	2019
Appraised by Other Organisations								
14	15/12/2023	15/12/2018			Aug 2018	Yes		2019
Retired Consultants								
15	07/04/25	09/04/15	25/03/14	09/09/2019	Aug 2018 (locum cover)		15/02/2018	2019

*require to be re-arranged following COVID-19
Drs 3 and 9's revalidation date was moved from 2020 to 2021 due to Covid 19

4 RECOMMENDATION

The Board is invited to note the content of this report.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives?	To ensure Board oversight of NHS Education for Scotland requirements for medical appraisal and revalidation.
Workforce Implications	Revalidation and appraisal are requirements to work as a doctor and essential to ensuring our continued medical workforce.
Financial Implications	No specific implications identified.
Route to the Board (Committee) Which groups were involved in contributing to the paper and recommendations?	Requested by the Board as part of annual workplan, and additional oversight through Clincial Gvoernance committee
Risk Assessment (Outline any significant risks and associated mitigation)	No significant risks identified
Assessment of Impact on Stakeholder Experience	Captures feedback on stakeholder experience and provides opportunity to improve this
Equality Impact Assessment	EQIA Screened – no identified implications
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	There are no identified impacts
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

Date of Meeting:	October 2020
Agenda Reference:	Item No: 10
Sponsoring Director:	Medical Director
Author(s):	Head of Corporate Planning and Business Support
	Clinical Effectiveness Team Leader
Title of Report:	Quality Assurance and Quality Improvement
Purpose of Report:	For Noting

1 SITUATION

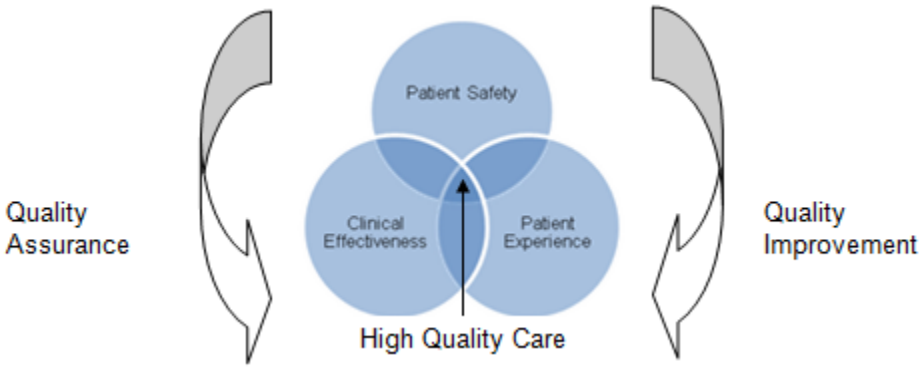
This report provides an update to The State Hospital Board on the progress made towards quality assurance and improvement activities since the last Board meeting in August 2020. The report highlights activities in relation to QA and QI and outlines how these relate to strategic planning and organisational 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 Clinical Quality Strategy sets out the direction, aims and ambitions for the continuous improvement of clinical care within The State Hospital. 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
- Evidence for quality including analysis of the national and local guidance and standards recently released and pertinent to The State Hospital
- Capacity Building for Quality Improvement

4 RECOMMENDATION

The Board are asked to note the content of this paper

Author:

Monica Merson

Head of Corporate Planning and Business Support

01555 842181

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	The Quality Improvement and Assurance report supports the Quality Strategy and Corporate Objectives by outlining the actions taken across the hospital to support QI and QA
Workforce Implications	Workforce implications in relation to further training that may be required for staff where policies are not being adhered to.
Financial Implications	No specific implications or impacts identified.
Route To Board	Requested through Board workplan, and further oversight through Clinical Governance Committee
Risk Assessment (Outline any significant risks and associated mitigation)	To give board oversight on potential risk identified through clinical audit, e.g. following evidence based practice.
Assessment of Impact on Stakeholder Experience	Impacts on staff, patients and carers outlined in reporting.
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 has been assessed and no specific impacts identified.
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One √ There are no privacy implications. □ There are privacy implications, but full DPIA not needed □ There are privacy implications, full DPIA included.

QUALITY ASSURANCE AND IMPROVEMENT IN THE STATE HOSPITAL

OCTOBER 2020

INTRODUCTION

Quality Assurance and Improvement in The State Hospital links to the Clinical Quality Strategy 2017 – 2020. The State Hospital Clinical Quality Strategy sets out the direction, aims and ambitions for the continuous improvement of clinical care within The State Hospital. 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.

ASSURANCE OF QUALITY

Clinical Audit

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

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

- Observation Policy Sub Heading Audit
- BBV Audit
- Record Keeping Audit
- Takeaway Audit
- Physical Equipment Audit
- Post Physical Intervention Audit

Findings from these included:

Observation Policy Sub Heading Audit

- Medical must improve their use of the observation review sub heading on RiO
- Nursing must improve their use of the observation review sub heading on RiO
- Consideration to be given to the use of sub headings to be included in all medical and nursing staff induction programmes

BBV Audit

- Ensure that all patients have an annual and admission BBV assessment and these are kept-up-to-date (annually) – information on those patients whose BBV assessment is not in date will be passed to the Advanced Practitioner for Infection Control for action.
- Improve the number of Annual BBV assessments completed on the BBV Annual Assessment form on RiO.
- Improve the number of patients tested for BBV - Information on patients who have not had BBV bloods taken will be passed to the Advanced Practitioner for Infection Control for action.

Record Keeping

- Excellent improvement with all patients seeing their RMO within the last 4 weeks
- Number of unvalidated entries has increased but reported into heads of services for action

Takeaway Audit

- A check of the forms should be completed to ensure that the Nurse in Charge is signing off the order.
- A reminder should be sent to all nursing staff to ensure they understand and follow the guidance
- Consistency needs to be brought in across all wards so patients are being treated the same no matter which ward they reside in.

Physical Equipment Audit

- Physical equipment not consistent across all wards
- Re-audit required within the next 6 months following the audit tool being updated to make it more relevant to The State Hospital.

Post Physical Intervention Audit

- The information on the Post Physical Intervention Assessment Form and Datix should always correspond
- For all incidents where the patient is taken to the floor, physical observations should be recorded (with a minimum of consciousness level being recorded if the patient is too highly aroused to take BP/pulse/respirations/ temperature) using the NEWS
- A quality check of Datix around the use of secure holds and thereafter the provision of refresher training to ensure staff input incident details correctly and understand why this is required

Audits currently underway, or due to commence include, Compliance to Treatment, Seclusion, POMH Prescribing Valproate, IM Haloperidol, Clozapine and Physical Equipment. We are currently awaiting guidance from national re the annual Catering Survey.

Variance Analysis Tool

Variance Analysis Tools are used within the organisation to give assurance that the key interventions linked to the CPA reviews are being completed. The following data refers to the Treatment and Rehabilitation VAT that monitors annual and intermediate reviews. During the current reporting period we saw a number of areas of good practice:

- Nursing completion of the VAT and carrying out of interventions continues to be good.
- Security attendance at the patient's case review has risen from 16% in Q2 to 48% in Q3. It should however be noted that this is still below the 60% LDP attendance target.
- Pharmacy supplying the patient with the MAPPS summary information has increased from 30% to 69% this quarter.
- Provision of the Psychology report at the patient's annual review has risen from 67% in Q2 to 81% in Q3. However, this is still lower on Lewis due to VAT completion.
- Dietetics discussing their report with the patient has risen from 0% in Q2 to 31% in Q3.

Points to Note

- Although we see a drop in OT interventions being carried out this is due in the main to Mull having no Occupational Therapist at the moment. New occupational therapists should be in post by the end of October 2020.
- There has been a slight increase in the number of PANSS assessments being carried out. New trainee psychiatrists joined the hospital at the start of August and have received PANSS training
- Although understandable, it should be noted than one of the main casualties of COVID-19 remains care attendance at the patient's case review. This normally sits around 30% but is currently at 17%.

Areas for Improvement

A new data collection process was implemented in response to Covid in April 2020 with all disciplines being sent an excel spreadsheet to complete for their interventions. Although most professions are engaging well with this process there are still challenges with some individuals not completing the spreadsheet and returning to Clinical Effectiveness for analysis. This is inspite of the information on non-completion being sent to department heads on a monthly basis.

- Overall completion for the quarter was 88% compared to 89% in the previous quarter There is still an issue with Medical VAT completion, which is at 71% in Q3 . This is due in the main to poor completion on Lewis at 36% and Arran at 60%. This poor completion on these hubs means that all medical interventions are lower than normal.
- Psychology VAT completion also continues to be low at 76%. This is due to poor completion on Arran at 50% and Lewis at 62%.
- Key Worker/Associate Worker attendance is currently at 40% on Iona.

Discussion Points

- There continues to be an issue with reviewing the patient's physical health in advance of the case review. This issue should be taken to MAC to clarify what this intervention entails and whose responsibility it is.

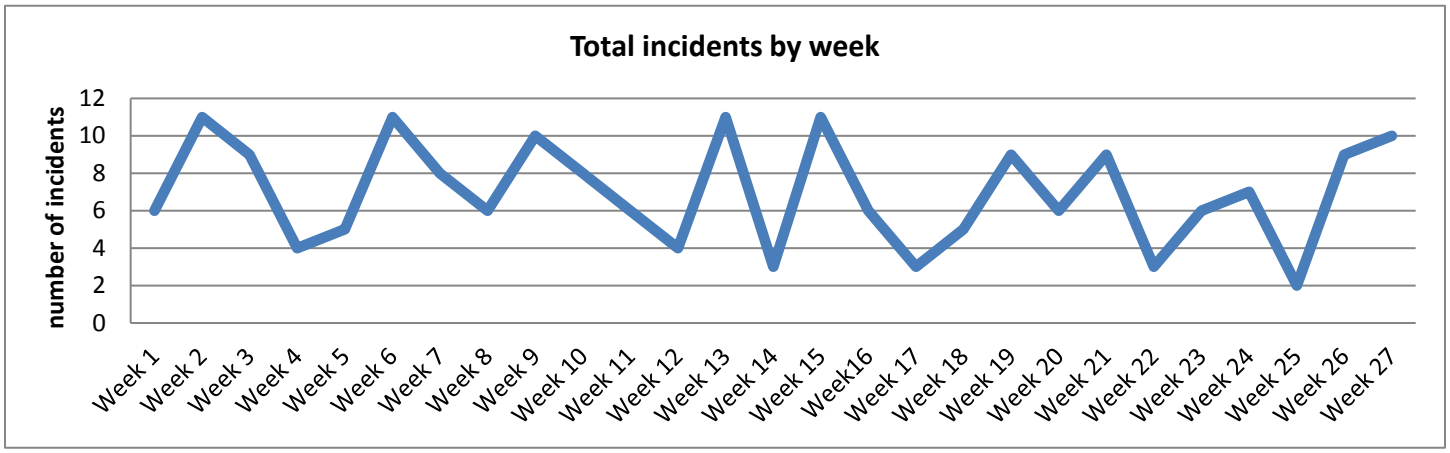
VAT Form Completion – July – Sept 2020

Hub	Medical	Nursing	Psych	Social Work	OT	Pharm	Skye AC	Security	Diet	Total
Arran n=6	60%	100%	50%	100%	67%	100%	-	83%	-	80%
Iona n=15	77%	98%	86%	93%	77%	100%	100%	100%	100%	92%
Lewis n=16	36%	93%	62%	93%	96%	100%	100%	100%	100%	87%
Mull n=9	100%	83%	100%	99%	83%	100%	100%	100%	100%	96%
Total n=46	71%	94%	71%	96%	83%	100%	100%	96%	100%	88%

Daily and Weekly Indicator Reports

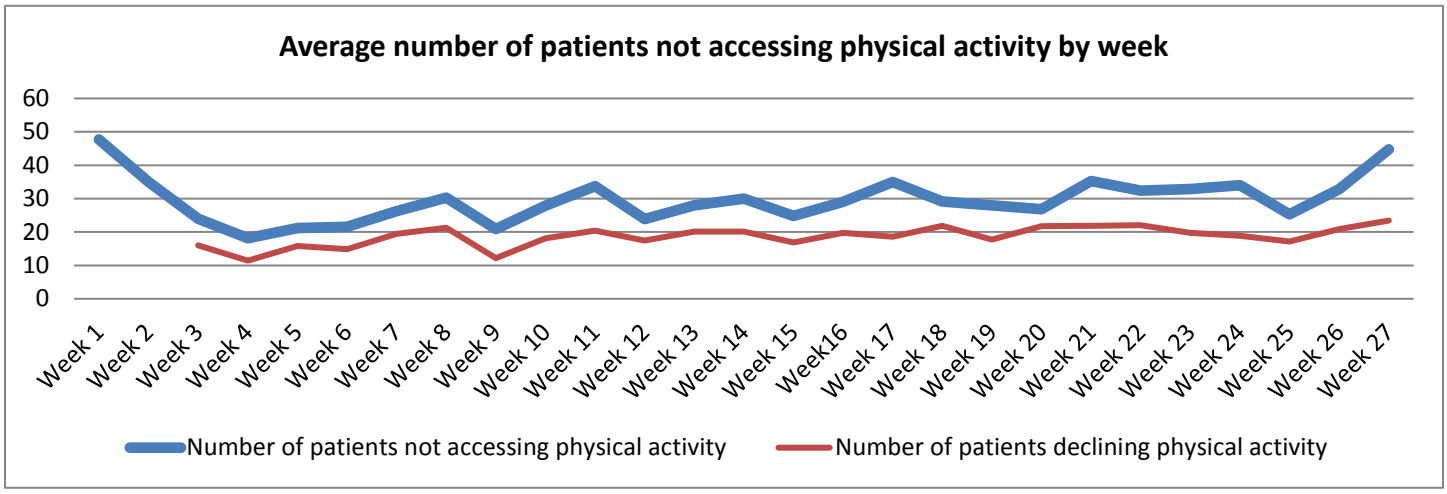
Clinical Effectiveness continue to collate and present the data that gives Gold Command the assurance that it is safe to continue with the Interim Operational Policy:

<u>Datix assaults, attempted assaults and behaviour</u>
Week 20 saw a decrease in incidents – 1 assault, 2 behaviour and 3 self harm. Week 21 saw a slight increase to 9 incidents – these were all behaviour related. Week 22 saw a reduction with a total of 3 incidents recorded over the week - 1 behaviour, 1 attempted assault and one self harm. Week 23 saw an increase in incidents with a total of 6 – 3 attempted assaults, 2 behaviour and 1 self harm. Week 24 saw a further increase with a total of 7 incidents: 1 assault, 3 behaviour and 3 self harm. Week 25 saw a reduction in the number of incidents with 1 attempted assault and 1 behaviour incident. Week 26 saw an increase to 9 incidents in total for the week: 2 assaults (one of these were patient to patient), 1 attempted assault, 4 behaviour and 2 self harm. Week 27 saw a further increase to 10 incidents: 2 assaults, 2 attempted assaults, 4 behaviour and 2 self harm.



Number of Patients Not Accessing Physical Activity

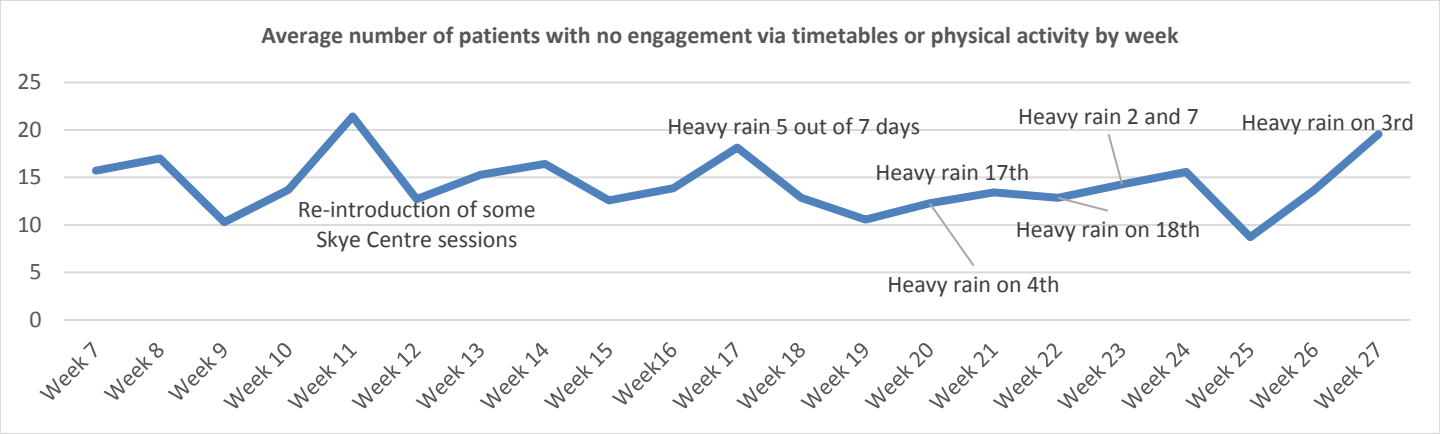
Week 20 saw a slight overall improvement in patients accessing physical activity with only one patient not engaging with physical activity during the week. Week 21 saw a slight increase to the number of patients not accessing physical activity. Week 22 saw more patients accessing physical activity. In total only 5 patients did not access physical activity at any point during week 22. Week 23 saw a slight increase in patients not accessing physical activity. In total only 2 patients did not access physical activity at any point during week 23. Week 24 saw a further slight increase to the average daily figure, with 2 patients, both from Iona 3, not accessing physical activity at any point in the week. Week 25 saw an improvement with more patients engaging with physical activity daily. The daily average improved from 34 to 25. Week 26 saw an increase in the average number of patients not engaging with fresh air. This increased from 25 to 33. Three patients did not engage with physical activity at any point in week 26. Week 27 saw a further increase with the average rising from 33 to 45. There were 5 patients that did not engage at any point in the week.



Patients not engaging with fresh air, physical activity or timetable sessions

Week 20 saw an increase in the average number of patients not engaging with fresh air, physical activity or timetable sessions during the week. Week 21 saw a further very slight increase. Week 22 saw a slight improvement, with no patients in the hospital not engaging with fresh air, physical activity or a timetable

session at some point in week 22. In Week 23 the average number of patients not engaging with fresh air, physical activity or timetable sessions increased from 13 to 14. There was 1 patient who did not engage with any activity during the week. Week 24 saw an average increase from 14 to 16, although it should be noted that there were no patients across the hospital who did not engage at some point through the week with either fresh air, physical activity or a timetable session. Week 25 saw the best week yet for patients not engaging with fresh air, physical activity or a timetable session. The average reduced from 16 to 9. Week 26 saw the average increasing from 9 to 14. Only one patient in the hospital did not engage with any activity at any point in the week. Week 27 saw a further increase with the average rising from 14 to 20. No patients did not engage with an activity at some point in week 27. There was also heavy rain on 3rd October.



Quality Forum and Remobilisation Planning

The Quality Forum meets regularly to champion and lead the quality improvement initiatives across the hospital and raise awareness and understanding of QI approaches. The QI Forum has supported staff engagement activities with a view to building in quality improvement approaches and methods to recovery and renewal planning.

Through the staff engagement activity, a range of themes emerged. These are listed below and have been developed into a Driver Diagram to support QI activity:

- Staff Health and Wellbeing
- Digital transformation
- Building a personalised approach to care
- Increase in patient activity and improve physical health of patients
- Organisational and clinical effectiveness and reduction/ review of low value activities
- Organisational leadership and culture

As remobilisation planning continues, the QI Forum will continue to provide support to the Recovery and Innovation Group. The QI Forum will work across the hospital to support and embed QI approaches to innovation and learning using the model for improvement as a guiding approach.

TSH3030

The Quality Forum's TSH3030 QI project has been nominated for the Scottish Health Awards in the Innovation Category. We have also been shortlisted for an award for the Royal College of Psychiatrists Awards Category

16 - Psychiatric Team of the Year: Quality Improvement. The awards ceremony is being held virtually on 19th November 2020.

EVIDENCE FOR QUALITY

National and local evidence based guidelines and standards

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

Over a 12 month period, an average of 200 evidenced based guidance documents issued from a variety of recognised bodies can be reviewed for relevancy by the Standards and Guidelines Co-ordinator. During the period 1 June to 31 July 2020, 34 guidance documents have been reviewed, one of which requires the completion of an evaluation matrix in relation to Osteoporosis by the Physical Health Steering Group.

Body	Total No of documents reviewed	Documents for information	Evaluation Matrix required
Healthcare Improvement Scotland (HIS)	2	1	0
Mental Welfare Commission (MWC)	13	13	0
SIGN	1	0	1
National Institute for Health & Care Excellence (NICE)	18	0	0

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 gap analyses completion began again at the start of July 2020. The responsibility to review these gap analyses changed ownership from the PMVA Review Group to the Patient Safety Group which recommenced meetings in September 2020.

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 waiting on Project Lead to take to Patient Safety Group for review. Patient Safety commencing in new format in early August 2020.	15/01/2019
MWC	The use of seclusion	MHPSG (via Patient Safety)	Evaluation matrix in draft, waiting Director of Nursing to take to Patient Safety Group for review. Patient Safety commencing in new format in early August 2020.	10/10/2019
SIGN	Management of Osteoporosis and the prevention of fragility fractures	PHSG	Awaiting communication from the GP to arrange meeting to complete gap analysis	June 2020
NICE	Rehabilitation for adults with complex psychosis	MHPSG	Meeting arranged in October to review recommendations and compile gap analysis	August 2020
NICE	Anaphylaxis: Assessment and referral after emergency treatment	PHSG	Awaiting communication from the GP to arrange meeting to complete gap analysis	17/09/2020

For each of the Steering Groups available to review guidelines, a Guidelines Action Plan is created to record the progress of any outstanding recommendations to be achieved.

	Total Outstanding Recommendations	Total Outstanding Guidelines
Physical Health Steering Group	3	3
Mental Health Practice Steering Group	13	6
Medicines Committee	4	2
* Operational Model Monitoring Group	1	1

*The Guidelines Action Plan previously allocated to the Person Centred Improvement Steering Group was discussed at the Clinical Governance Group (CGG) who felt that the one outstanding action was best suited to sit under the Patient Day Group. Given that CGG were unsure when the Patient Day Group would be re-established the issues was therefore presented to the Operational Model Monitoring Group (OMMG) for discussion. The OMMG noted that this was an outstanding piece of work and would sit within the

remobilisation plan. It was recognised that a paper is being prepared for Silver Command to capture weekend activity and would therefore be progressed via this route

Quality Improvement Capacity Building

Developing capacity and capability for individuals and teams across TSH has been a focus of activity for the Quality Forum. National training is available through NHS Education for Scotland (NES), specifically the Scottish Improvement Leaders Programme (ScIL) and Scottish Coaching and Leading for Improvement (SCLIP) training, are particularly useful within TSH.

Scottish Coaching and Leading for Improvement (SCLIP) training has recently been opened up for application, 14 applicants were submitted form TSH with seven staff have been successful in securing provisional places on SCLIP (subject to final confirmation from NES), form these sic are Senior Charge Nurses and 1 Practice Education Facilitator.

The Scottish Improvement Leaders Programme (ScIL) programme have also commenced a recruitment process for ScIL, the State Hospital have secured three places on cohort 30, starting in January 2021.

The Quality Forum will engage with these national programmes and support TSH applicants as they progress through the development opportunities.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 October 2020
Agenda Reference:	Item No: 12
Sponsoring Director:	Interim HR Director
Author(s):	Head of Human Resources/ HR Advisor
Title of Report:	Attendance Management 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 August 2020.

2 BACKGROUND

Within the report, the data used is extracted from two different sources, SWISS (the national source) and SSTS (the local source). The tables, graphs and narrative within the report indicate the source of data used for the information presented.

National reporting and comparative Board tables are based upon the SWISS data, and it is this figure which is referred to by Scottish Government.

The local data from SSTS enables the breakdown of absence figures to a departmental level.

3 ASSESSMENT

SWISS

The sickness absence figure from 1 August 2020 to 31 August 2020 is 6.99% with the long/short term split being 5.57% and 1.42% respectively. The total hours lost for this period is which 6,340.15 equates to 38.96 wte.

The monthly absence figure has increased by 0.88% from July 2020 figure of 6.11%. The July 2020 long/short term split was 4.98% and 1.13% respectively.

The current average rolling 12-month sickness figure is 5.73% for the period 1 September 2019 to 31 August 2020. The long/short term split is 4.38% and 1.36% retrospectively. The total hours lost for this period is 65,315.73 which equates to 33.50 wte.

The average rolling 12-month sickness absence figure represents a decrease of 0.81% when compared to the same period last year (with the average rolling absence figure from 1 September 2018 to 31 August 2019 reported at 6.54%).

SSTS

Industrial injuries represented 0.12% (1437.23 hours) of available hours from 1 September 2019 2019 to 31 August 2020.

Table 1

Sickness Absence Hours by Reason - 1 September 2019 to 31 August 2020
Source: SSTS

Absence Reason Description	Total (SL+Il) Working Hours Lost	Total & inc Industrial Injury
Anxiety/stress/depression/other psychiatric illnesses	35408.65	40.57 %
Other musculoskeletal problems	9870.35	11.31 %
Gastro-intestinal problems	5638.80	6.46 %
Other known causes - not otherwise classified	5494.26	6.30 %
Back problems	4185.12	4.80 %
Injury, fracture	4075.13	4.67 %
Cold, cough, flu - influenza	3562.95	4.08 %
Unknown causes/not specified	3460.52	3.97 %
Ear, nose, throat (ENT)	2567.10	2.94 %
Benign and malignant tumours, cancers	2542.80	2.91 %
Chest & respiratory problems	1995.05	2.29 %
Heart, cardiac & circulatory problems	1947.46	2.23 %

Table 1 details all absences amounting to greater than 2%. Source: SSTS

Table 2

Absence - Work Related Stress
Source: SSTS

Year	Month	Anxiety/Stress/Depression/Other Psychiatric Illness	Work Related Stress (new)
2019	**Jun**	22	0
	Jul	20	0
	Aug	25	3
	Sep	26	4
	Oct	24	1
	Nov	30	1
	Dec	32	1
2020	**Jan**	27	1
	Feb	25	3
	Mar	30	0
	Apr	25	1
	May	22	0
	Jun	27	1
	July	29	1
	August	27	1

During the month of August 2020, 27 staff were absent with anxiety/stress/depression/ other psychiatric illnesses, and there was 1 new case of sickness absence due to work related stress.

LONG / SHORT TERM ABSENCE BREAKDOWN - NATIONAL DATA (SWISS)

Chart 1 provides a rolling monthly comparison of long and short-term absence from SWISS for the State Hospital only.

Chart 1

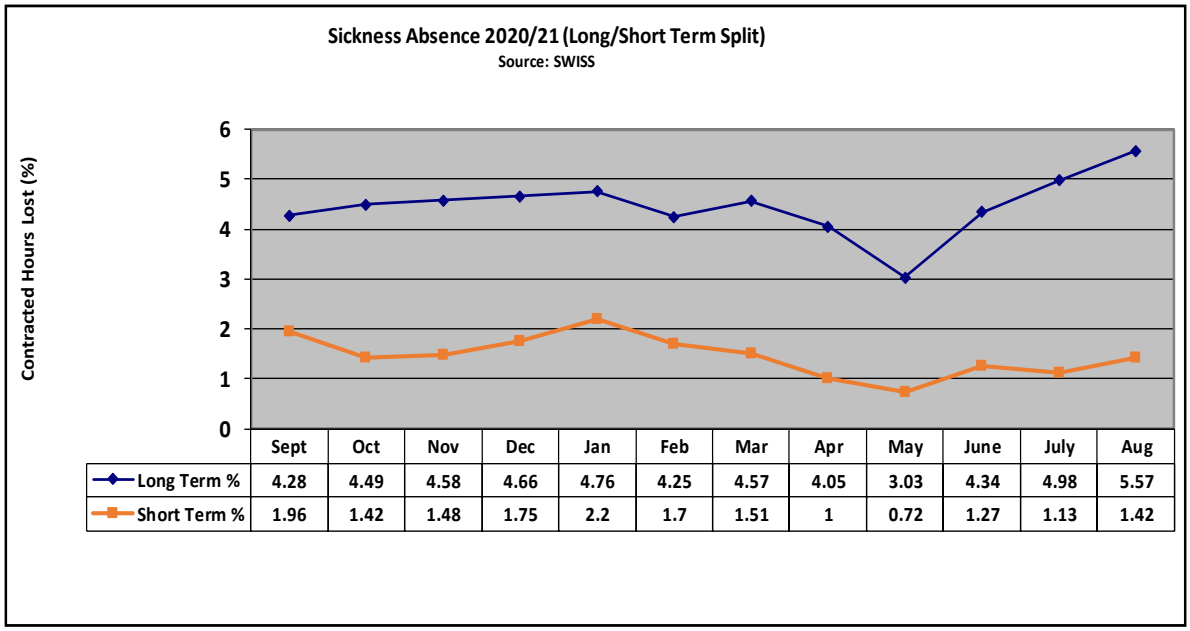
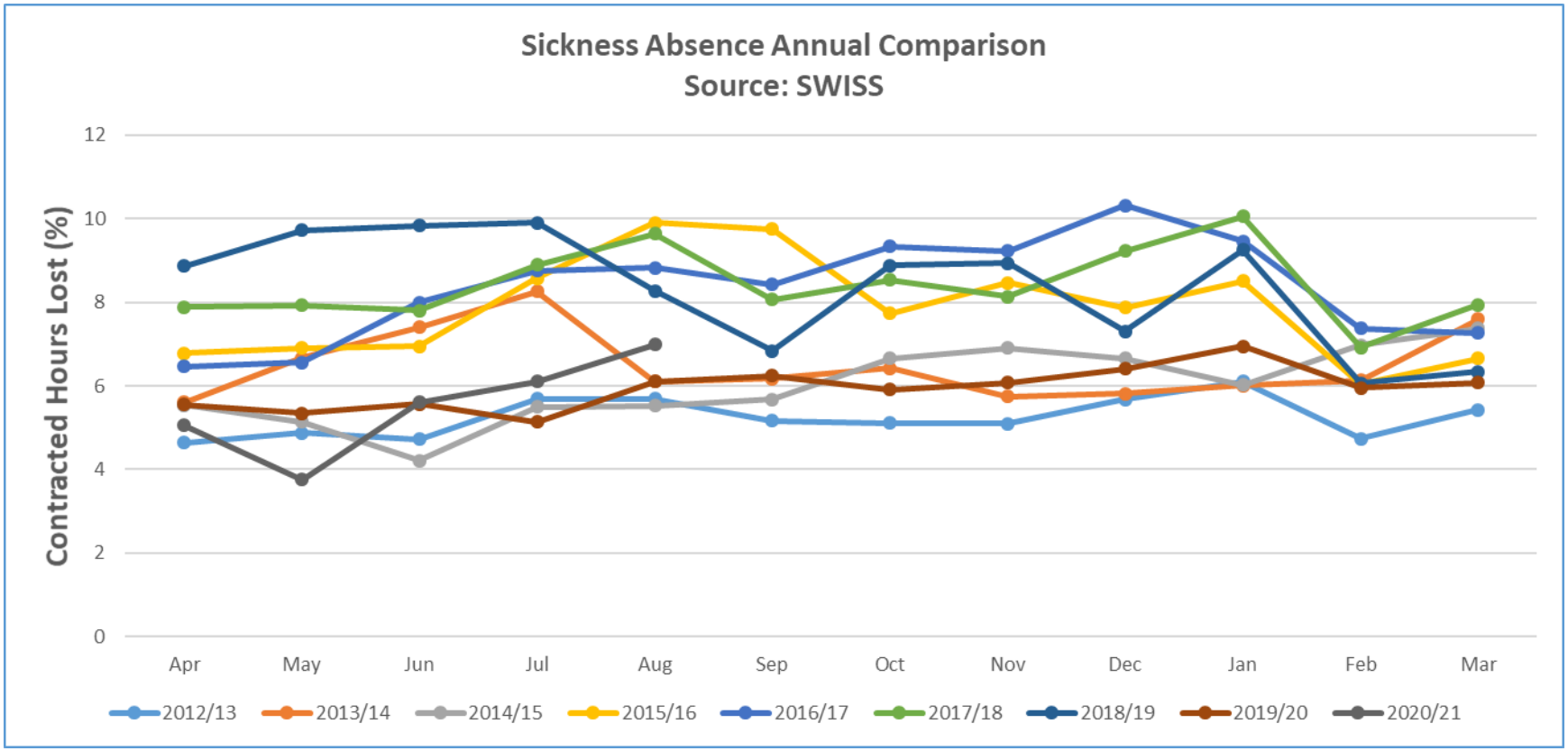


Chart 2 - YEARLY AND MONTHLY COMPARISON - details the breakdown in percentage of sickness absence for the financial years 2012/13, 2013/14, 2014/15, 2015/16, 2016/17, 2017/18, 2018/19, 2019/20 and 2020/21. This data is derived from SWISS.



Year/Month	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2012/13	4.64	4.88	4.72	5.69	5.69	5.17	5.11	5.09	5.67	6.1	4.74	5.42
2013/14	5.6	6.67	7.4	8.26	6.1	6.17	6.42	5.74	5.81	6.01	6.13	7.59
2014/15	5.54	5.13	4.21	5.49	5.52	5.68	6.66	6.91	6.65	6.02	6.98	7.38
2015/16	6.78	6.91	6.94	8.58	9.9	9.75	7.73	8.47	7.87	8.51	6.04	6.66
2016/17	6.46	6.56	8	8.75	8.83	8.42	9.34	9.23	10.32	9.46	7.38	7.26
2017/18	7.89	7.93	7.81	8.89	9.64	8.07	8.53	8.13	9.23	10.06	6.92	7.94
2018/19	8.87	9.73	9.84	9.9	8.27	6.83	8.88	8.93	7.3	9.25	6.06	6.34
2019/20	5.55	5.34	5.56	5.13	6.1	6.24	5.91	6.07	6.41	6.95	5.95	6.07
2020/21	5.05	3.75	5.61	6.11	6.99							

Table 3 - TSH Workforce Summary - August 2020 (Source: SSTS)

Table 3 details the percentage sickness absence, leave and training for July 2020.

The State Hospital – July 2020						
Job Family	Absence Percentages this period (Leave / In Post Hours Ava)					
	Sickness (SSTS)	Annual /PH (SSTS)	Mat /Pat (SSTS)	Training (SSTS)	Other (SSTS)	Total
Psychology	2.2%	16.6%	4.7%	0.0%	4.7%	28.2%
Medical	3.2%	12.3%	16.6%	0.0%	2.5%	34.6%
AHP'S	1.9%	14.4%	0.0%	0.0%	15.3%	31.6%
Chief Executive	0.0%	12.0%	0.0%	0.0%	0.0%	12.0%
Finance	2.5%	15.4%	2.8%	0.0%	0.0%	20.7%
Human Resources	0.0%	16.0%	0.0%	0.0%	2.5%	18.5%
Other Nursing & AHPs	2.1%	16.4%	2.6%	0.0%	2.6%	23.7%
Skye Centre	13.5%	13.4%	3.0%	0.0%	3.5%	33.5%
Security	7.5%	13.8%	0.0%	0.0%	4.0%	25.3%
Housekeeping Services	9.8%	17.0%	0.0%	0.0%	0.6%	27.4%
Estates Maintenance	0.5%	10.1%	0.0%	0.0%	5.7%	16.2%
Facilities	0.0%	16.1%	0.0%	0.0%	5.5%	21.5%
Overall Nursing	11.7%	13.5%	1.4%	0.0%	5.7%	**32.4%**
The State Hospital (Total)	8.1%	14.1%	1.8%	0.0%	4.5%	**28.5%**

PLEASE NOTE:

- Overall Nursing Total includes Arran, Iona, Lewis, Mull Hub and Clusters, Nursing Pool H&C and Person Centred Improvement.
- TSH Sickness Absence rates have been updated from August 19 data onwards to include 'sick leave', 'unpaid sick leave', 'industrial injury', 'accident involving a third party' and 'injury resulting from a crime of violence' in line with ISD sickness absence reporting.
- Note: Other Nursing & AHPs includes Nursing Resources, Admin, PAs and Operational Team.

Table 4 - TSH Workforce Summary - Nursing Wards - August 2020 (Source: SSTS)

Table 4 details the percentage sickness absence, leave and training within Nursing for June 2020.

The State Hospital Nursing Wards – July 2020						
Job Family	Absence Percentages this period (Leave / In Post Hours Ava)					
	Sickness (SSTS)	Annual /PH (SSTS)	Mat /Pat (SSTS)	Training (SSTS)	Other (SSTS)	Total
The State Hospital Nursing Wards						
Lewis Hub & Cluster	11.2%	11.5%	1.3%	0.0%	10.8%	34.7%
Iona Hub & Cluster	11.5%	12.4%	1.4%	0.0%	4.0%	29.3%
Mull Hub & Cluster	7.2%	15.9%	0.0%	0.0%	3.8%	26.9%
Arran Hub & Cluster	18.1%	13.6%	3.5%	0.1%	2.3%	37.6%
Nursing Pool H&C	8.5%	17.8%	0.0%	0.0%	6.7%	33.0%
Overall Nursing	11.7%	13.5%	1.4%	0.0%	5.7%	**32.4%**

PLEASE NOTE:

- TSH Sickness Absence rates have been updated from August 19 data onwards to include 'sick leave', 'unpaid sick leave', 'industrial injury', 'accident involving a third party' and 'injury resulting from a crime of violence' in line with ISD sickness absence reporting.

Table 5 - Breakdown of Absence

Table 5 provides a breakdown of all sickness absence by roster location for the period 1 August to 31 August 2020. (Source: SSTS)

Target details applied to data (All Sick Leave %)
< 5% Green
5 - 7% Amber
> 7% Red

Target details applied to data (Total Lost %) - Target equates to 23.5%
< 23.5% Green
23.5 - 25.5% Amber
> 25.5% Red

Roster Location	In Post Avg WTE	Short Term Sick Hours	Short Term Sick%	Long Term Sick Hours	Long Term Sick%	All Sick Leave Hours	All Sick Leave %	All Industrial Injury Hours	All Industrial Injury %	TOTAL LOST HOURS	TOTAL LOST %
SH - Allied Health Professional Service	11.82	0.00	0.00 %	221.00	11.26 %	221.00	11.26 %	0.00	0.00 %	677.17	34.51 %
SH - Clinical Admin	18.64	53.60	1.73 %	104.75	3.38 %	158.35	5.12 %	0.00	0.00 %	639.54	20.66 %
SH - Clinical Effectiveness	9.77	0.00	0.00 %	0.00	0.00 %	0.00	0.00 %	0.00	0.00 %	309.50	19.08 %
SH - Clinical Operations Management Team	5.83	0.00	0.00 %	0.00	0.00 %	0.00	0.00 %	0.00	0.00 %	140.00	14.46 %
SH - Finance	5.23	0.00	0.00 %	0.00	0.00 %	0.00	0.00 %	0.00	0.00 %	226.25	26.05 %
SH - Forensic Network	4.48	0.00	0.00 %	0.00	0.00 %	0.00	0.00 %	0.00	0.00 %	38.35	5.15 %
SH - Hotel Services	12.83	22.50	1.06 %	0.00	0.00 %	22.50	1.06 %	0.00	0.00 %	516.25	24.23 %
SH - Housekeepers	33.47	123.00	2.21 %	508.50	9.15 %	631.50	11.36 %	0.00	0.00 %	1748.25	31.45 %
SH - Hub Arran - Arran Ward 1	27.00	62.68	1.40 %	687.82	15.34 %	750.50	16.74 %	0.00	0.00 %	1492.10	33.28 %
SH - Hub Arran - Arran Ward 2	26.00	55.96	1.30 %	258.84	5.99 %	314.80	7.29 %	0.00	0.00 %	1421.92	32.93 %
SH - Hub Iona - Iona Ward 1	27.00	0.00	0.00 %	731.96	16.32 %	731.96	16.32 %	197.06	4.39 %	1636.64	36.50 %
SH - Hub Iona - Iona Ward 2	24.00	61.80	1.55 %	328.42	8.24 %	390.22	9.79 %	0.00	0.00 %	1380.12	34.63 %
SH - Hub Iona - Iona Ward 3	24.80	268.56	6.52 %	294.12	7.14 %	562.68	13.66 %	0.00	0.00 %	1326.23	32.20 %
SH - Hub Lewis - Lewis Ward 1	23.32	0.00	0.00 %	280.78	7.25 %	280.78	7.25 %	0.00	0.00 %	1276.83	32.97 %
SH - Hub Lewis - Lewis Ward 2	26.28	132.16	3.03 %	423.02	9.69 %	555.18	12.72 %	0.00	0.00 %	1397.16	32.02 %
SH - Hub Lewis - Lewis Ward 3	24.63	0.00	0.00 %	306.42	7.49 %	306.42	7.49 %	0.00	0.00 %	1137.18	27.80 %
SH - Hub Mull - Mull Ward 1	23.00	74.92	1.96 %	32.62	0.85 %	107.54	2.82 %	0.00	0.00 %	849.84	22.25 %
SH - Hub Mull - Mull Ward 2	27.00	90.50	2.02 %	670.19	14.95 %	760.69	16.96 %	0.00	0.00 %	1622.37	36.18 %
SH - Hub Senior Charge Nurses	12.00	0.00	0.00 %	153.81	7.72 %	153.81	7.72 %	0.00	0.00 %	479.83	24.08 %
SH - Human Resources	5.58	0.00	0.00 %	0.00	0.00 %	0.00	0.00 %	0.00	0.00 %	119.70	12.92 %
SH - Information	6.60	0.00	0.00 %	0.00	0.00 %	0.00	0.00 %	0.00	0.00 %	336.50	30.70 %
SH - Infrastructure	8.59	0.00	0.00 %	93.50	6.55 %	93.50	6.55 %	0.00	0.00 %	236.00	16.54 %
SH - Laundry	0.99	1.00	0.61 %	0.00	0.00 %	1.00	0.61 %	0.00	0.00 %	5.00	3.04 %
SH - Learning Centre	7.46	37.90	3.06 %	0.00	0.00 %	37.90	3.06 %	0.00	0.00 %	180.65	14.58 %
SH - Man Cent Support	6.89	0.00	0.00 %	0.00	0.00 %	0.00	0.00 %	0.00	0.00 %	47.15	4.12 %
SH - Med. Consultants and PA	14.44	8.00	0.33 %	0.00	0.00 %	8.00	0.33 %	0.00	0.00 %	864.00	36.04 %
SH - Non Executives/Chairman	5.00	0.00	0.00 %	0.00	0.00 %	0.00	0.00 %	0.00	0.00 %	0.00	0.00%
SH - Nursing Pool	28.48	25.70	0.54 %	569.00	12.03 %	594.70	12.57 %	0.00	0.00 %	1322.20	27.96 %
SH - Nursing Practice Development / (SM)	4.20	22.50	3.23 %	0.00	0.00 %	22.50	3.23 %	0.00	0.00 %	97.50	13.98 %
SH - Operational Team	4.00	0.00	0.00 %	0.00	0.00 %	0.00	0.00 %	0.00	0.00 %	30.00	4.52 %
SH - Personal Assistants	4.60	0.00	0.00 %	112.50	14.73 %	112.50	14.73 %	0.00	0.00 %	180.20	23.59 %
SH - Person Centred Improvement Services	2.60	0.00	0.00 %	0.00	0.00 %	0.00	0.00 %	0.00	0.00 %	75.00	17.37 %
SH - Psychology	21.05	52.50	1.50 %	0.00	0.00 %	52.50	1.50 %	0.00	0.00 %	781.00	22.35 %
SH - Security Admin	0.67	0.00	0.00 %	0.00	0.00 %	0.00	0.00 %	0.00	0.00 %	25.00	22.47 %
SH - Security Bank	0.24	0.00	0.00 %	0.00	0.00 %	0.00	0.00 %	0.00	0.00 %	0.00	0.00%
SH - Security Control	11.64	0.00	0.00 %	333.50	17.25 %	333.50	17.25 %	0.00	0.00 %	544.00	28.14 %
SH - Security Operational Team	9.40	0.00	0.00 %	0.00	0.00 %	0.00	0.00 %	0.00	0.00 %	122.60	7.85 %
SH - Security Reception	19.32	29.50	0.92 %	376.00	11.72 %	405.50	12.64 %	0.00	0.00 %	982.50	30.62 %
SH - Skye Centre	32.27	45.25	0.84 %	494.03	9.22 %	539.28	10.06 %	0.00	0.00 %	1472.39	27.47 %
SH - Social Work	1.00	0.00	0.00 %	0.00	0.00 %	0.00	0.00 %	0.00	0.00 %	0.00	0.00%
SH - Supplies	5.60	0.00	0.00 %	0.00	0.00 %	0.00	0.00 %	0.00	0.00 %	225.00	24.19 %
SH - Support - Estates	22.51	4.50	0.12 %	0.00	0.00 %	4.50	0.12 %	0.00	0.00 %	769.85	20.60 %
SH - Unsocial Hours - Ad Hoc	1.00	0.00	0.00 %	0.00	0.00 %	0.00	0.00 %	0.00	0.00 %	0.00	0.00%
Total	**591.22**	**1172.53**	**1.19 %**	**6980.78**	**7.11 %**	**8153.31**	**8.30 %**	**197.06**	**0.20 %**	**26731.77**	**27.23 %**

National Comparison with NHS Scotland and The State Hospital - August 2020

	Absence Rate			Instances			Absence Reason	
	Total	Long Term [1]	Short Term [2]	Total	Long Term [1]	Short Term [2]	Yes	No [3]
Scotland	**4.75**	**3.24**	**1.52**	**22,531**	**7,694**	**14,837**	**19,716**	**2,815**
NHS Ayrshire & Arran	3.75	2.59	1.16	1,114	383	731	1,029	85
NHS Borders	4.82	3.28	1.54	438	143	295	376	62
NHS National Services Scotland [4]	3.23	2.33	0.90	276	93	183	263	13
NHS 24	7.18	4.71	2.47	407	122	285	365	42
NHS Education For Scotland	0.53	0.42	0.11	35	15	20	28	7
Healthcare Improvement Scotland	1.25	0.54	0.71	24	4	20	22	2
NHS Health Scotland [4]	-	-	-	-	-	-	-	-
Public Health Scotland [4]	1.62	1.11	0.52	57	14	43	45	12
Scottish Ambulance Service	6.33	4.75	1.58	715	331	384	670	45
The State Hospital	6.99	5.57	1.42	108	61	47	98	10
National Waiting Times Centre	5.12	3.37	1.75	291	96	195	250	41
NHS Fife	4.75	3.33	1.43	1,174	456	718	1,069	105
NHS Greater Glasgow & Clyde	5.20	3.68	1.52	5,674	2,186	3,488	5,198	476
NHS Highland	4.84	3.30	1.54	1,357	422	935	881	476
NHS Lanarkshire	5.30	3.93	1.37	1,712	733	979	1,542	170
NHS Grampian	3.69	2.21	1.48	2,065	498	1,567	1,592	473
NHS Orkney	4.93	3.20	1.73	87	28	59	79	8
NHS Lothian	4.57	2.73	1.84	3,588	951	2,637	3,147	441
NHS Tayside	5.01	3.48	1.53	1,719	585	1,134	1,498	221
NHS Forth Valley	5.80	4.13	1.67	863	342	521	811	52
NHS Western Isles	5.15	3.38	1.77	156	49	107	134	22
NHS Dumfries & Galloway	4.56	2.81	1.75	598	171	427	550	48
NHS Shetland	2.23	0.93	1.30	73	11	62	69	4

EASY COMPLIANCE REPORT

DATE	No of Staff Included	No of staff reporting sick*	No of staff referred to EASY**	Compliance Rate %
July 2019	649	49	40	81.63%
August 2019	657	60	56	93.33%
September 2019	657	59	46	78%
October 2019	653	52	49	94.23%
November 2019	655	65	52	80%
December 2019	653	78	79	101%
January 2020	660	72	63	87.5%
February 2020	655	61	60	98.4%
March 2020	655	47	49	104.2%
April 2020	667	38	33	86.84%
May 2020	671	37	31	83.78%
June 2020	667	58	58	100%
July 2020	668	39	38	97.43%
August 2020	665	67	54	80.58%

**Note: number of staff reporting sick includes all staff whose first day of sickness falls within the time period noted.*

***Note: includes those who were referred to EASY but their absence was not recorded on SSTS.*

EASY Reporting Reasons for Absence from January 2020 to August 2020

Reasons For Absence	Number of Staff							
	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug
Gastrointestinal/Vomiting/Diarrhoea	14	12	11	6	9	14	7	10
Colds/Coughs/Flu	16	*	12	*		*	*	*
Infectious Diseases	*	*	*				*	
Mental Health	*	12	9	*	*	11	8	9
Unknown/Not Specified		*						*
Injury/Fracture	*	5		*	5	*	*	6
Backache	*	*	*		*	5	6	6
Chest and Respiratory	*	5	*	*				
Ear Nose and Throat	5	*	*	*	*	*		*
Headache and Migraine	5	*	*	6	*	6	*	*
Genitourinary and Gynaecological	*	*	*	*		*	*	*
Other Musculoskeletal	*	*	*		*	*	*	*
Other known cause	5	*	*	5	*	*	5	*
Dental/Oral	*							
Skin Disorder					*			
Cardiac & Circulatory				*			*	*
Eye Problems			*					*
Burns/poisoning/frostbite								
Pregnancy Related Disorder	*	*				*	*	
Asthma				*				
Nervous System Disorders						*		
Cancer								*
Total	63	60	49	33	31	58	38	54

**indicates less than 5 members of staff.*

COVID-19 RELATED SPECIAL LEAVE

Please note 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 COVID19 related special leave from week ending 15 March 2020 until week ending 02 August 2020, including the monthly totals, are provided below.

Source: SSTS

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

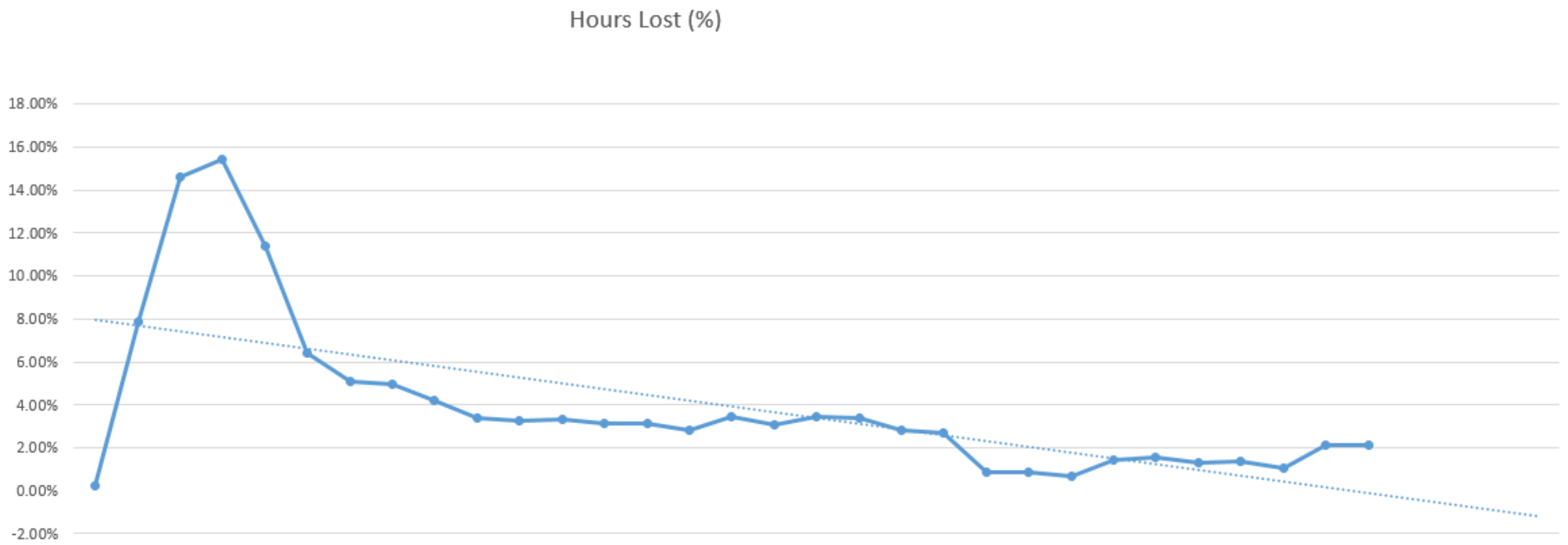
Week Ending (WE)	Total Hours Lost	Total Hours Lost (%)
15 March 2020	55.9	0.25%
22 March 2020	1723.64	7.85%
29 March 2020	3204.94	14.59%
05 April 2020	3382.02	15.42%
12 April 2020	2509.73	11.42%
19 April 2020	1441.03	6.43%
26 April 2020	1131.65	5.06%
03 May 2020	1111.28	4.97%
10 May 2020	939.86	4.20%
17 May 2020	757.76	3.39%
24 May 2020	730.55	3.26%
31 May 2020	741.04	3.31%
07 June 2020	692.43	3.11%
14 June 2020	704.65	3.16%
21 June 2020	632.15	2.84%
28 June 2020	768.5	3.45%
05 July 2020	768.5	3.07%
12 July 2020	766.8	3.44%
19 July 2020	750	3.37%
26 July 2020	630.37	2.83%
02 August 2020	593.88	2.67%

09 August 2020	191.86	0.86%
16 August 2020	194.26	0.87%
23 August 2020	145.02	0.65%
30 August 2020	317.55	1.43%
06 September 2020	345.35	1.56%
13 September 2020	293.08	1.33%
20 September 2020	299.72	1.36%
27 September 2020	233.85	1.06%

Month	Total Hours Lost	Total Hours Lost (%)
March 2020	6154.08	6.33%
April 2020	8086.04	8.50%
May 2020	3530.62	3.56%
June 2020	3239.32	3.39%
July 2020	3133.85	3.17%
August 2020	1045.39	1.06%
September 2020	1340.73	1.42%

Chart 1

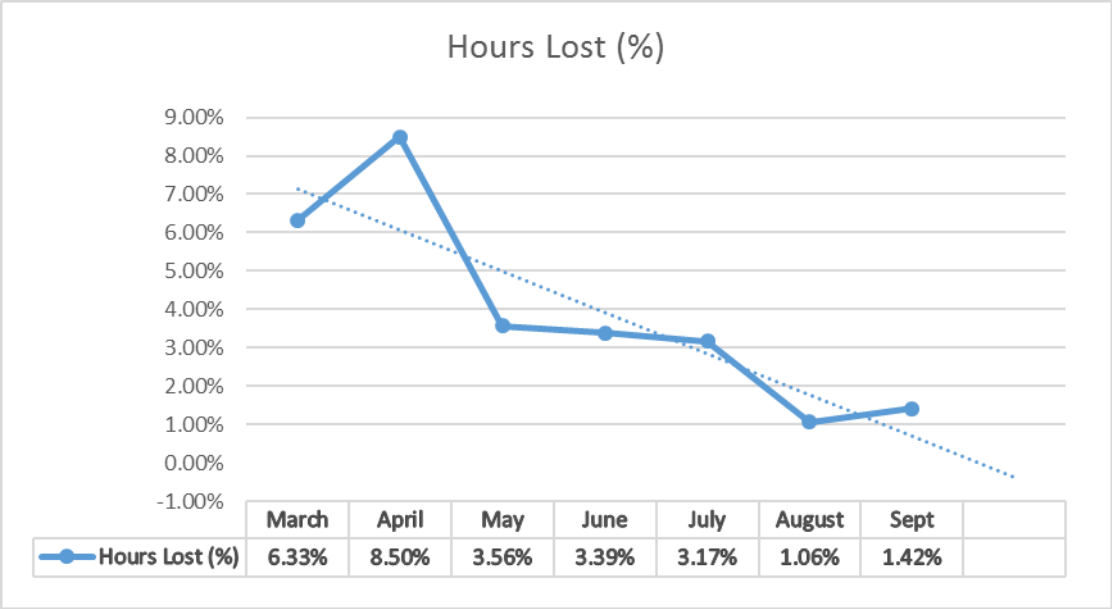
The chart below shows the trend in weekly reported COVID19 related special leave.



As indicated in the above chart, COVID related absence peaked during the week ending 5 April (15.42%) and there has been a general downward trend since then.

Chart 2

The chart below shows monthly trend of reported COVID19 related special leave.



As shown above, the COVID19 related special leave peaked in April 2020 with a monthly figure of 8.5% and there has been a general downward trend since that time.

Sickness Absence Management During COVID19 Crisis

Following the outbreak of Covid-19 it was agreed towards the end of March 2020 to pause all routine sickness absence stage meetings and to only progress final stage or end of process meetings.

Long term sickness absence cases have continued to be reviewed by managers, with support from HR Advisors as appropriate, to support staff to return to their role or an adjusted role to support the wider organisation. Such cases have been managed remotely where possible during this period.

It was agreed in July 2020 to resume all formal sickness absence stage meetings and where possible these should be managed remotely. The stage meetings and associated reviews provide an important support mechanism for staff and will help to ensure that health and wellbeing problems and concerns associated with the pandemic are identified at an early stage and that any support needs are promptly addressed.

4. RECOMMENDATION

The Board is invited to note the contents of this report.

Author:
Linda McWilliams
Head of HR
01555 842259

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 Partnership Forum Which groups were involved in contributing to the paper and recommendations.	Interim Director of HR Partnership Forum
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 **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:	22 October 2020
Agenda Reference:	Item No: 14
Sponsoring Director:	Finance & Performance Management Director
Author(s):	Finance & Performance Management Director
Title of Report:	Internal Audit – service provision
Purpose of Report:	For Decision

1 SITUATION

The purpose of this report is to consider the Audit Committee's recommendation to the Board with regard to the ongoing internal audit service provision.

2 BACKGROUND

Following a competitive tender process in early 2017, RSM were appointed as Internal Auditor to the State Hospital. Under the terms of the tender, their appointment – effective 1st April 2017 – was on the basis of "3 years with the possibility of 2 further 1 year extensions on a one plus one basis".

Since their appointment, RSM have completed three full years as our internal audit providers, and are underway with their fourth year, for which the extension was agreed by the Board in October 2019 taking the appointment to 31st March 2021.

Should the option not be taken for the second one-year extension, the lead time for tendering the service provision to start in April 2021 is such that the process would be required to start in autumn 2020, therefore this matter requires approval at this meeting.

3 ASSESSMENT

At this point, the Board have the option either to extend the appointment under the terms noted above, or to initiate a new tender for the service provision effective 1st April 2021.

Further to discussion at the Audit Committee on 8th October 2020, it is the Audit Committee's recommendation that the option is taken to extend RSM's engagement by one year to 31st March 2022.

4 RECOMMENDATION

It is proposed that, under the terms of the 2017 tender and their subsequent appointment and acceptance thereof, the Board invites RSM to accept a second extension of one year to that appointment – effectively extending their period of service provision to 31st March 2022.

At that time, it will be a requirement for the service then to go to tender for a new three-year period (with options again to extend to four or five years) – the tender process for which would be expected to begin in autumn 2021.

Author:
Robin McNaught
Director of Finance and Performance Management
01555 842004

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives?	Essential provision of a quality internal audit service
Workforce Implications	None
Financial Implications	None – in line with current budget
Route to the Committee Which groups were involved in contributing to the paper and recommendations?	Audit Committee Chair of the Audit Committee and Finance & Performance Management Director
Risk Assessment (Outline any significant risks and associated mitigation)	No significant risks identified
Assessment of Impact on Stakeholder Experience	None identified
Equality Impact Assessment	No identified implications.
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	No identified implications
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One √ There are no privacy implications. □ There are privacy implications, but full DPIA not needed □ There are privacy implications , full DPIA included.

Board Paper 20/71

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 October 2020
Agenda Reference:	Item No: 15
Sponsoring Director:	Director of Finance and Performance Management
Author(s):	RSM
Title of Report:	Internal Audit Report – Board Pack Quality Assessment
Purpose of Report:	For Noting

1 SITUATION

Internal auditors RSM recently completed a review and assessment of the quality of The State Hospital Board Pack for management.

2 BACKGROUND

This report was submitted to the Audit Committee on 8 October 2020, where it was agreed that the report should be shared with the Board.

3 ASSESSMENT

The assessment highlighted many areas of good practice in reporting to the Board, as well as a range of low priority actions to further enhance the operation of current governance practice. Overall the internal audit opinion was that the Board can take reassurance that the controls upon which the organisation relies upon in each area are suitably designed, consistently applied and operating effectively.

4 RECOMMENDATION

The Board is invited to **note** the RSM report.

Authors: RSM

Board Contact:
Margaret Smith
Board Secretary
01555 842012

Board Paper 20/71
MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	To inform the Board on recent assessment of board pack quality.
Workforce Implications	No direct implications identified.
Financial Implications	None directly considered.
Route To Board Which groups were involved in contributing to the paper and recommendations.	On recommendation from the Audit Committee .
Risk Assessment (Outline any significant risks and associated mitigation)	No direct consequences and the report is for information.
Assessment of Impact on Stakeholder Experience	No direct impacts identified.
Equality Impact Assessment	Not required.
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	Not applicable.
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One X There are no privacy implications. □ There are privacy implications, but full DPIA not needed □ There are privacy implications , full DPIA included.

BOARD PACK QUALITY ASSESSMENT FOR MANAGEMENT 1.20/21

The State Hospitals Board for Scotland

FINAL

21 September 2020

THE POWER OF BEING UNDERSTOOD
AUDIT | TAX | CONSULTING

RSM

CONTENTS

1. EXECUTIVE SUMMARY

Why we completed this audit

We have completed an exercise to provide you with information about the quality of your Board reporting. The main purpose is to highlight how you can further develop your agendas, reports and minutes that are presented to the Board to bring them more into line with good practice seen elsewhere both within and outside your sector.

Conclusion

We evidenced many areas of good practice in reporting to the Board, ranging from the number of items discussed, to the timeliness of issue and the level of Board reports as a percentage of Board items. However, we have raised 19 low priority actions with management to further enhance the current governance process operating. These relate to, but are not limited, to time bound Agenda items, the structure of the papers presented and the link between key issues contained within Reports and risk / risk management

Internal audit opinion:

Taking account of the issues identified, the Board can take reasonable assurance that the controls upon which the organisation relies to manage the identified area are suitably designed, consistently applied and operating effectively.

Key findings

The Board Agenda's for The State Hospitals Board for Scotland (TSH) highlights a focus on mainly items for noting and information. Items for Decision and monitoring / assurance were significantly lower in comparison than other organisations reviewed as part of the benchmarking exercise. Consequently, the agenda appears to have an overt focus on noting matters, followed by decision making and then monitoring. This can create excessive levels of papers and take the focus of the Board away from more important areas. That said, from our review of the minutes, we found that the Board monitors closely the progress of actions against an action log on a quarterly basis and so our concerns were mitigated.

TSH Board Cover Reports do not appear to summarise how the matter being reported links to strategic or corporate objectives, risk and risk management, compliance and implications such as financial, people and regulatory. The CEO report consisted of a verbal update in February and April. Whilst, we understand, due to the very unusual circumstances in play at the moment, we would recommend the use of a standardised template which would ensure a consistency of information provided. This may be better undertaken when matters begin to settle down.

Reports contain their own unique identifier on the Agenda. However, this was not referenced within the Minutes. The term 'paper was presented' is used which does not allow the reader to summarily link the report in question to the minutes presented.

Set out in the following section is the report background, proceeded by our detailed findings and it highlights several areas we have identified as good practice alongside some areas for focus. It also includes the results of our benchmarking exercise which is further detailed in Appendix A.

This report is for Management purposes only and to support further consideration we have provided an action plan for Management in section 4 of the key actions for improvement. In addition, we have included an example Board report layout in Appendix B according to principles of best practice.

2. BACKGROUND

Introduction

As discussed with management, we have completed an Internal audit exercise to provide you with information about the quality of the governance material as part of your Board reporting. The main purpose was to highlight how you can further develop these key documents to bring them more into line with good practice seen elsewhere both within and outside your sector.

The Board Agenda sets out the items that you will have considered demonstrating that you have fully discharged your key governance responsibilities, as set out in your Terms of Reference, in the eyes of key stakeholders including the Scottish Government.

The Board Minutes are an important legal document which represents the actions of the Board including the rationale for reasonable decision-making which should be clear and transparent as well as demonstrate the quality of Board discussions.

The Board Reports are equally as important as they form the connection between the above documents and are upon which decisions are made, performance monitored, and key matters noted for information and assurance purposes.

Approach

We have developed three checklists based on good practice identified across several sectors, one for each of the following documents:

- Agenda (A)
- Reports (R)
- Minutes (M).

Each checklist has a series of questions focussing on:

- Planning
- Structure
- Content.

There are just over 100 questions in total which we have applied only to those documents listed. Examples of the questions are set out below:

Area	***Example questions***
Planning	Does the Agenda state:
	- Name of the organisation?
	- Purpose of the meeting (e.g. AGM, Board, Committee)?
	- Date of the meeting?
	- Start and End times of the meeting?
	- Place of the meeting?

Structure	Does the Cover Sheet make explicit links to the Corporate Risk Register?
Content	Do the minutes clearly set out the rationale for decision reached?

Our benchmarking exercise involved comparing your information with 21 organisations. The information we were able to compare includes:

- Number of pages
- Number of items
- Percentage of items that are reports
- Start time of board meeting
- Percentage of the items for decision
- Percentage of the items for monitoring / assurance
- Percentage of the items for information / noting.

The purpose of this was to identify where you perform well, where you are similar and where you might want to reflect.

Scope and context

We have used the checklists to review only the following Board documents relating to the meetings listed below:

- Board Agenda – 27 February 2020 and 23 April 2020
- Board Reports – 27 February 2020 and 23 April 2020
- Board Minutes – 19 December 2019, 27 February 2020 and 23 April 2020.

Board meetings occur on a bi-monthly basis with additional private sessions held at the same frequency. Private meetings are used to discuss sensitive issues such as Whistleblowing and Site Security. These meetings are papered, and minutes are produced in the same way as regular Board meetings. Outcomes from public sessions are displayed on the organisation's website.

We were unable to benchmark against the full set of criteria due to the absence of time allocation for agenda items, coupled with the same for end times on the sample reviewed. This means the following benchmark graphs are for Management information only:

- Planned length of meeting
- Actual length of board meeting
- Percentage of planned meeting time allocated to standing items
- Percentage of planned meeting time allocated to decision items
- Percentage of planned meeting time allocated to monitoring / assurance items
- Percentage of planned meeting time allocated to information / noting items

3. DETAILED FINDINGS

Areas of good practice

The Board packs we reviewed for February and April 2020 generally followed a consistent format in relation to the agenda, minutes and report templates. Standing items are always deliberated at the start of each meeting which ensures approval of minutes, matters arising, and declarations of interest are regularly managed.

Reports contain their own unique identifier on the Agenda however this was not referenced within the Minutes. The term 'paper was presented' is used which does not allow the reader to summarily link the report in question to the minutes provided. This is a 'quick win' since it is a finding Management can easily reflect before the next meeting.

We found that 88% of agenda items had a physical report associated with them which meant verbal updates were low within the Board packs reviewed. That said, this level could be increased above 90% if the Chair, CEO and Audit Committee reports were presented in a written format. Discussions held outside of quarterly meetings are documented and incorporated within minutes which match the format of those provided at the main Board session. This ensures there is a record of what has taken place. The private minutes are circulated to Board Members as a Private Meeting Pack which ensures Members are kept fully informed.

Other areas of good practice include:

- ✓ The use of a Board Work Plan to inform future Agenda's;
- ✓ Annual review of the Board Work Plan;
- ✓ The Board report authors are clear;
- ✓ High member attendance across the previous two Board meetings despite current challenges;
- ✓ Board agendas are developed by the Board Secretary, CEO, Exec team and the Chair;
- ✓ Board Members provide insight and guidance regarding the level of report detail required;
- ✓ Board papers are issued 4 to 5 days in advance of the next meeting;
- ✓ The Board is comprised of 5 Non-Executive Directors excluding the Chair;
- ✓ Member attendance is recorded on a register and incorporated within the minutes;
- ✓ Minutes include a number for each item on the Agenda;
- ✓ The reference number of all reports are presented on the Agenda;
- ✓ Private meeting discussions are documented and included within a Private Meeting Pack;
- ✓ Annual review of the Board pack structure / content by Members;
- ✓ Detailed Background section on Report Cover;
- ✓ Approved public minutes are placed on the TSH website;
- ✓ Register of Member attendance;
- ✓ Actions are assigned to an owner and monitored via an actions log;
- ✓ The Chair and Board Secretary are easily identifiable from the Agenda and Minutes; and
- ✓ Declarations of interest, Standing Items and Matters Arising are covered at the beginning of each meeting.

Areas of potential good practice seen elsewhere

We highlight below areas of potential good practice seen in operation at other organisations / companies which TSH may wish to consider.

1. Precise planned times could be stated for each item on the agenda. That would demonstrate where the focus of the meeting was.
2. Throughout the minutes of the meeting, tables could be added to show clear documentary evidence of how the Board challenged the Executive together with the Executive's response.
3. The Chairs summary of the key points from the discussion could be included in minutes to demonstrate that there is clarity and understanding of what has been agreed.
4. An item at the end of the meeting entitled "Reflection of the Meeting" could be used. This provides a real time opportunity for Members to express their views on the meeting and the quality of the papers.

Areas for further review / development

Our assessment identified some opportunities to further develop the Board Pack. There is currently no explicit link within Board reports to key strategic risks and corporate objectives although we note there is a Corporate Risk Register in use at TSH.

We also noted some inconsistencies between the inclusion of start and end times, the latter of which was absent from the Agenda and Minutes reviewed. Agenda items provided did not include a time allocation to support with agenda management. In addition, the benchmark analysis revealed the number of items for information / noting was high compared with other organisations and that items for decision were lower. This may be indicative of an increased focus on operational issues for the Board. Other areas for further development include:

- Where Board Members are absent, the minutes should explicitly state whether the individual(s) provided feedback or comment on the papers;
- Identify the Minute Taker on the Board Agenda;
- Record the actual time spent on Agenda items to ensure consistency with the times planned for each item; and
- Reference the Report Identifier provided on the Agenda within the Minutes.

Key Recommendations

- Management should revaluate the benefit of Any Other Business (AOB) at the end of the meeting as this can lead to additional expectations which could be difficult to manage.
- Include the time frame allocated to agenda items to support with agenda management.
- Develop a CEO report template to assist in the standardisation of information provided in terms of both consistency and format.
- The Board Cover Report should be further developed to summarise how the matter being reported links to risk and risk management.
- Continue to explore the opportunity to establish a Member's website for Board papers.
- Record the time allocated to Agenda items to ensure these remain consistent with the planned time for items.
- The Board Minutes should reference the exact paper/report identifier provided on the Agenda to ensure better clarity between the minutes and agenda items for discussion.

- Include a section for Chairs summary at the end of each decision point to make it clearer to the reader what the Chair's summation was for a decision.
- Include a link between Public and Private Board meetings in terms of the date and time on each set of Agenda's and set of minutes.

Benchmarking information

We have completed our benchmarking exercise which involved comparing information about some aspects of the Board agenda, reports and minutes with other companies and organisations. The findings are below:

Where you compare well

- Time of meeting
- Board reports as a percentage of board items

Where you are the same / similar

- Number of items on the agenda

Where you might need to review / reflect

- Number of pages in the board pack
- Percentage of board items for decision
- Percentage of board items for monitoring / assurance
- Percentage of board items for information / noting

We were unable to benchmark the following information due to the absence of time allocation to agenda items and planned / actual meeting end times:

- Planned length of meeting
- Actual length of board meeting
- Percentage of planned meeting time allocated to standing items
- Percentage of planned meeting time allocated to decision items
- Percentage of planned meeting time allocated to monitoring / assurance items
- Percentage of planned meeting time allocated to information / noting items

We have included charts in relation to the above in section 4 for information.

4. MANAGEMENT ACTION PLAN

The table below sets out the recommendations following our completion of the checklist and benchmarking exercise and provides an opportunity to formally monitor any agreed response.

No.	Recommendations	Priority	Implementation date	Management response, responsible individual
	Structure			
1	The Board Cover Reports should commence in the following order to aid with dissemination of key ideas: • Purpose; • Action Required; • Key Issues and • Background	Low	January 2021	Board Secretary: Management will update the format of Board reports pending the outcome of the Scottish Government Review through the NHS Board Chairs Group regarding content/format of Board reporting (Once for Scotland).
	Agenda			
2	The Agenda should have an end time, and in the same way as starting the meeting, it is equally important to end the meeting on time.	Low	September 2020	Board Secretary: Management accept the Recommendation and will reflect this change before the next Board meeting.
3	Consider the inclusion of Key Agenda Items for the next meeting to promote forethought.	Low	September 2020	Board Secretary: Management accept the recommendation and reflect at the next Board meeting.
4	Management should revaluate the benefit of Any Other Business (AOB) at the end of the meeting as this can lead to additional expectations which could be difficult to manage. AOB can be removed if: • A draft agenda is circulated in advance of the next meeting and;	Low	December 2020	Board Secretary and Chair: The Chair has considered this and commented that an AOB section allows flexibility should a late piece of business arise. Giving consideration to this, this is something that has not been over-used at TSH Board.

No.	Recommendations	Priority	Implementation date	Management response, responsible individual
	• Members are asked for any other items for consideration.			
5	Include the time frame allocated to agenda items to support with agenda management.	Low	September 2020	Board Secretary: Management accepted this recommendation and will include estimated agenda times next to items from next meeting.
	Board Reports			
6	Develop a written CEO report to assist in the standardisation of information provided in terms of format and consistency.	Low	Complete on consideration with the CEO and subject to national approach.	Board Secretary and CEO: Board Secretary to reviewing scope to formalise CEO reporting into a written format. This will be dependent upon national reporting framework being developed under a "once for Scotland "approach.
7	Summarise the Key Issues contained within a report into a standalone header to ensure these are highlighted to the reader.	Low	Complete on consideration with the CEO and subject to national approach.	Board Secretary and CEO: This will depend on national reporting framework being developed under a "once for Scotland "approach.
8	The Board Cover Report should be further developed to summarise how the matter being reported links to risk and risk management and implications such as legal, equality, diversity, financial, and regulatory.	Low	September 2020	Board Secretary: Believes this can be developed further and confirmed report authors do not consistently complete the Monitoring section contained within reports appropriately.

No.	Recommendations	Priority	Implementation date	Management response, responsible individual
	This will enable Board Members to ascertain more quickly the key factors in relation to the Report. This could be achieved through accurate completion of the Monitoring Section within individual reports and moving this toward the front cover.			
9	Include the contact detail for Author(s) to ensure follow up queries can be directed appropriately.	Low	September 2020	Board Secretary: Management accepted this recommendation and will reflect the reports to ensure report author details and included.
	Minutes			
10	Continue to explore the opportunity to implement a Member's website so that users can access information in a centralised and virtual platform such as Simplifie.	Low	February 2021	Board Secretary: Members website has been put on hold because TSH have been exploring Office 365 however this has not provided the functionality required. TSH is considering Admin Control (used widely across NHS Scotland). Chair has also noted that this may present difficulties for a smaller Board in maintaining and supporting this function.
11	Record the time allocated to Agenda items to ensure these remain consistent with the planned time for items.	Low	September 2020	Board Secretary: Management accepted this recommendation and will include estimated agenda times next to items from next meeting.

12	Include the role of Minute Taker next to the name of the appropriate individual, usually this is the Company Secretary or Governance Manager.	Low	September 2020	Board Secretary: Management accepted this recommendation and will endeavour to reflect before the next Board meeting.
13	Explicitly state whether a Member provided queries / questions in their absence.	Low	September 2020	Board Secretary: Management accepted this recommendation.
14	The Board Minutes should reference the exact paper/report identifier provided on the Agenda to ensure better clarity between the minutes and agenda items for discussion.	Low	September 2020	Board Secretary: Management accepted this recommendation.
15	Include a section for Chairs summary at the end of each decision point to make it clearer to the reader what the Chair's summation was for a decision.	Low	Complete on consideration with Chair	Board Secretary and Chair: Board Secretary to discuss this option with the Chair re summarised document at the end of meeting minutes to confirm key decisions taken during the meeting.
16	Include a meeting start and end time to ensure the meeting does not exceed 3-4 hours as this can be detrimental to concentration levels.	Low	September 2020	Board Secretary: Management accepted this recommendation.
17	Include a link between Public and Private Board meetings in terms of the date / time on each set of Agenda's and minutes to ensure stakeholders can identify when a public session ends, and a private session begins.	Low	September 2020	Board Secretary: Management accepted this recommendation and will amend Public Session minutes to include a reference of when the Private Session is due to commence.

18	Record the time allocated to Agenda items within the Minutes to ensure these remain consistent with the planned time for items.	Low	September 2020	Board Secretary: Management accepted this recommendation.
19	Include a summary of key decisions made during the meeting so Members can readily refer if required later.	Low	Complete on consideration with Chair	Board Secretary and Chair: Chair and Board Secretary to discuss this option with the Chair re summarised document at the end of meeting minutes to confirm key decisions taken during the meeting.

APPENDIX A – BOARD PACK BENCHMARKING

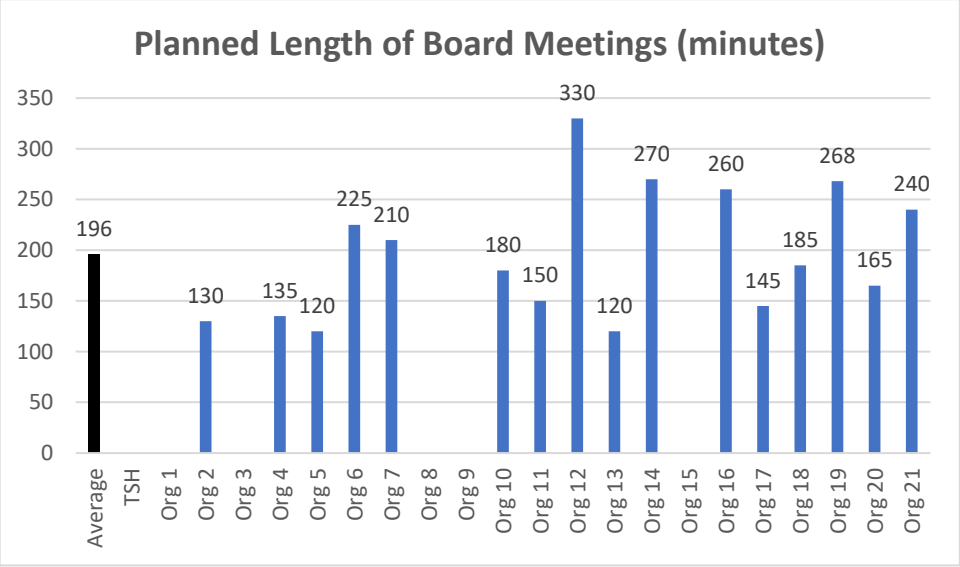
Please find below the output from our benchmarking exercise so that you can see the results in more detail.

We compared The State Hospitals Board for Scotland with:

- Ten (10) Housing Associations
- Three (3) NHS Trusts
- Two (2) Regulators
- Three (3) Financial Services companies
- Two (2) Charities
- One (1) Private Limited Company.

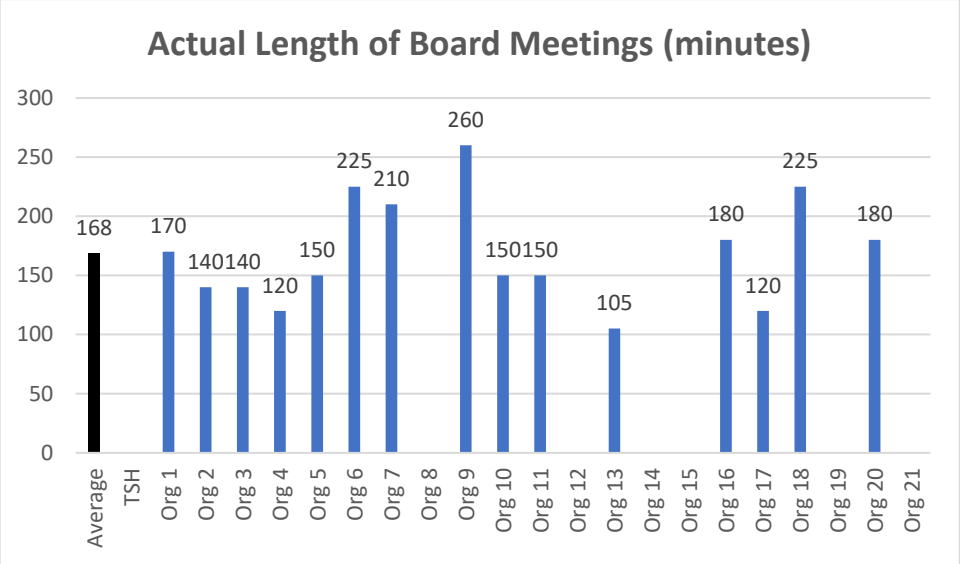
Please note that any benchmarking should be treated with caution as sometimes you may not be always not comparing like for like. However, we have included this information as it should stimulate debate amongst management and Board members.

Table 1 (Information only)



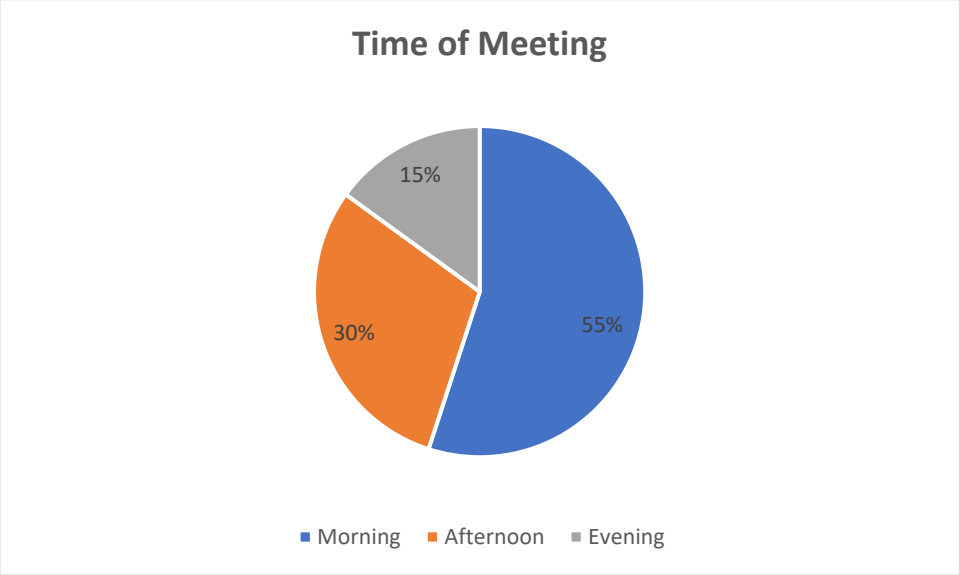
TSH does not record the meeting start and end time on the Minutes / Agenda so we were unable to benchmark this data however we have included the data set for information purposes only to provide insight into the average length of Board meetings held elsewhere.

Table 2 (Information only)



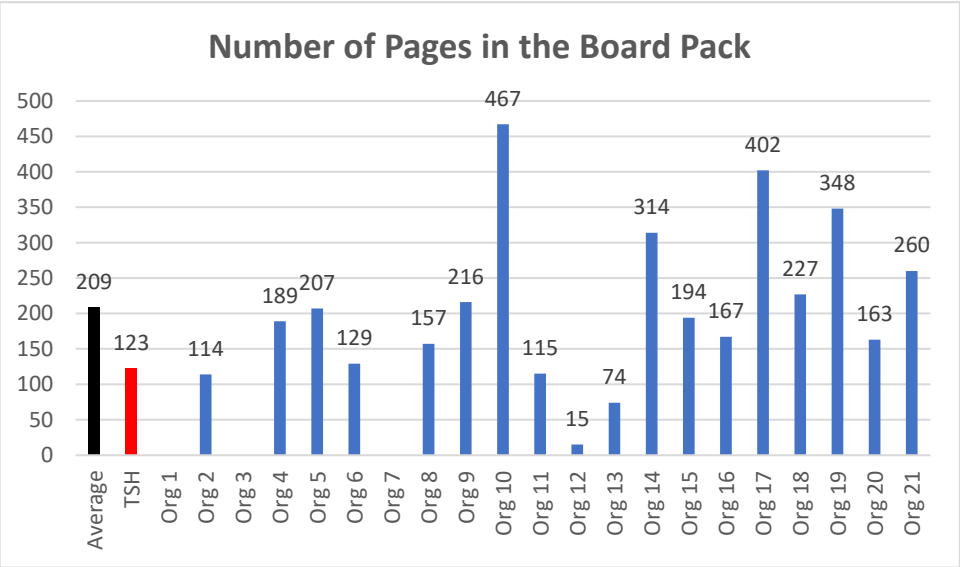
TSH does not record the meeting start and end time on the Minutes / Agenda so we were unable to benchmark this data however we have included the data set for information purposes only to provide insight into the actual length of Board meetings held elsewhere.

Table 3



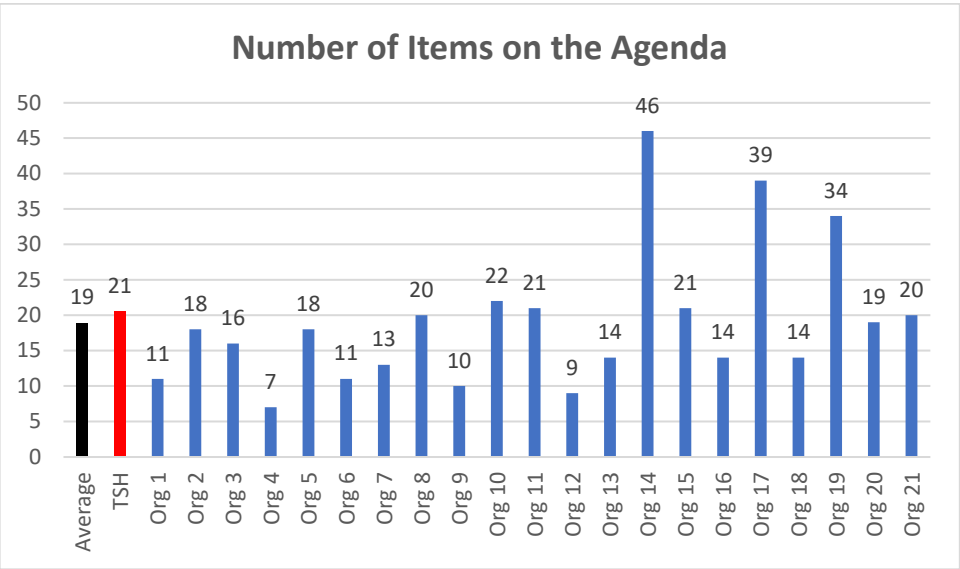
TSH commences its Board meetings in the morning like 55% of the comparison group.

Table 4



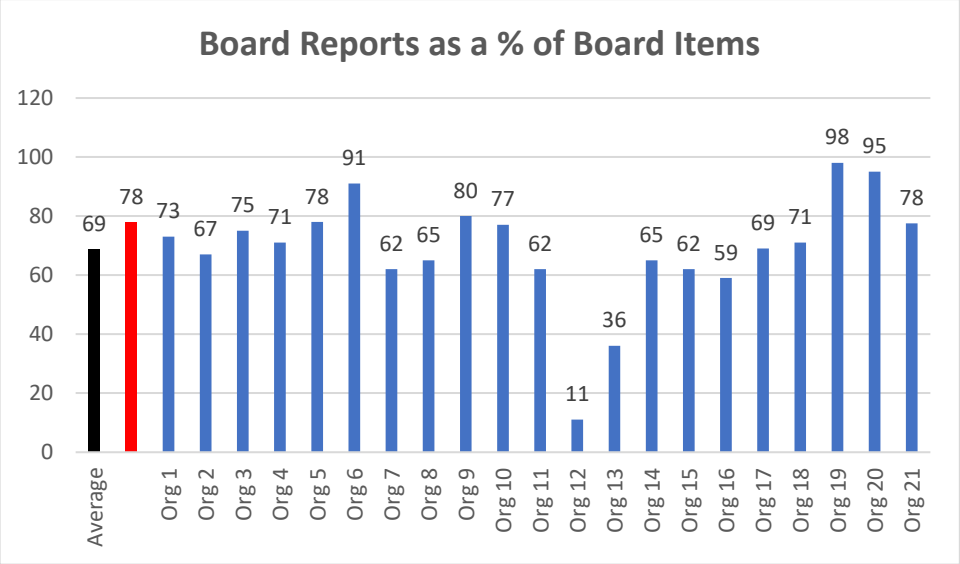
The average number of pages (123) in TSH's Board pack was the fifth lowest in the group.

Table 5



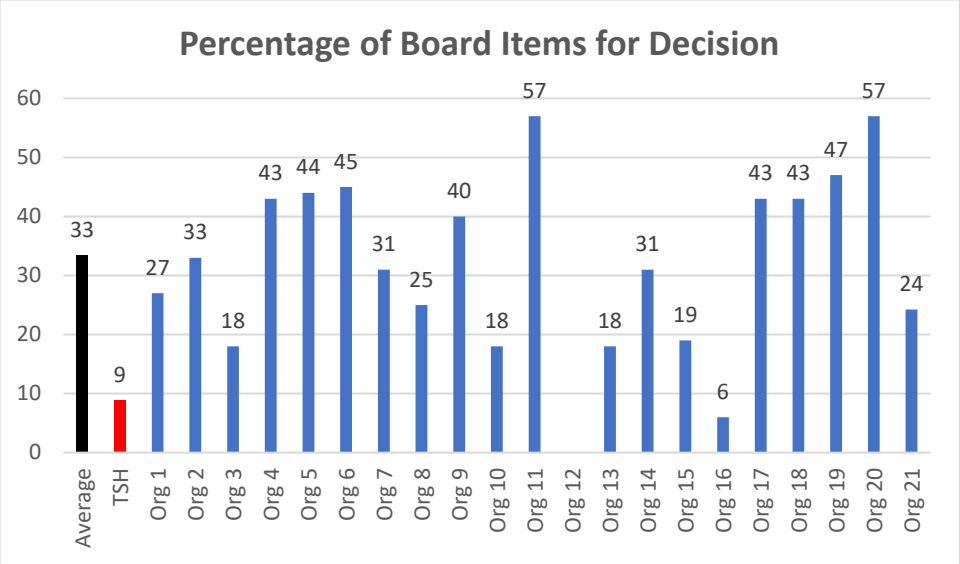
The average number of Items in the Board packs reviewed were 21 which is slightly above the average. This may be due to the high number of items for Information / Noting. (See Table 9)

Table 6



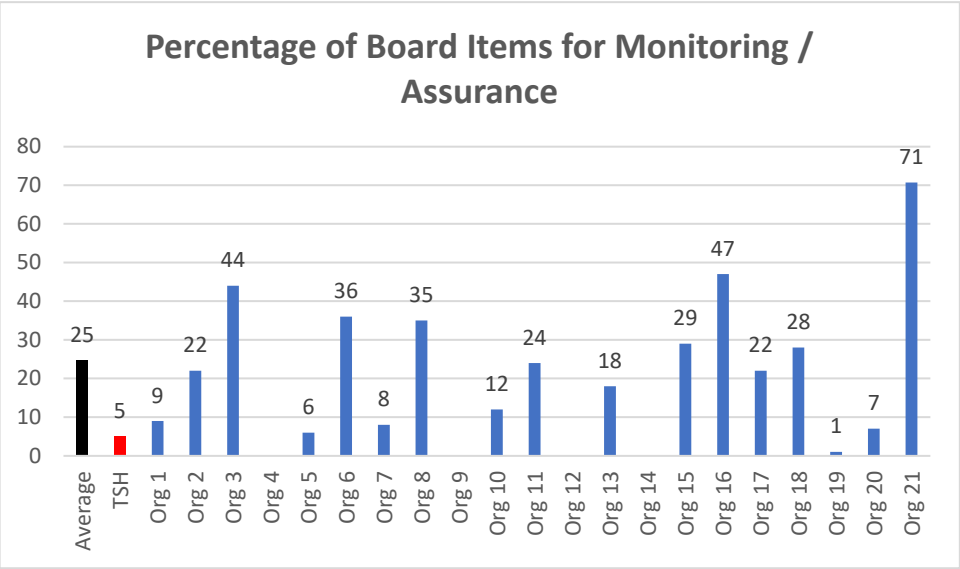
The percentage of Board items that are a formal report is slightly above the average. This could be due to the higher number of reports for Information / Noting. (See Table 9).

Table 7



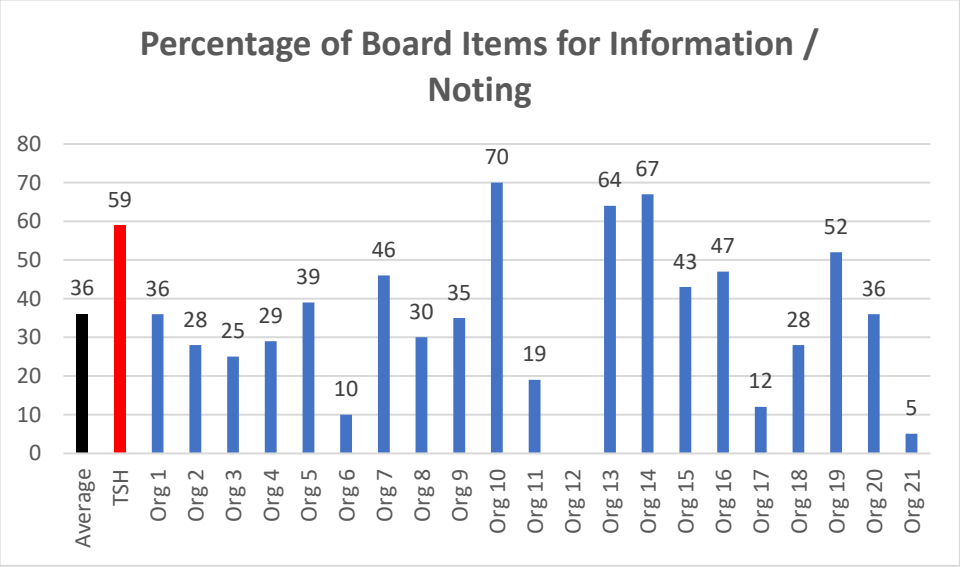
TSH has a low percentage of Board Items for Decision / Approval in relation to the average which reflects the operational performance nature of some of the items being presented to the Board.

Table 8



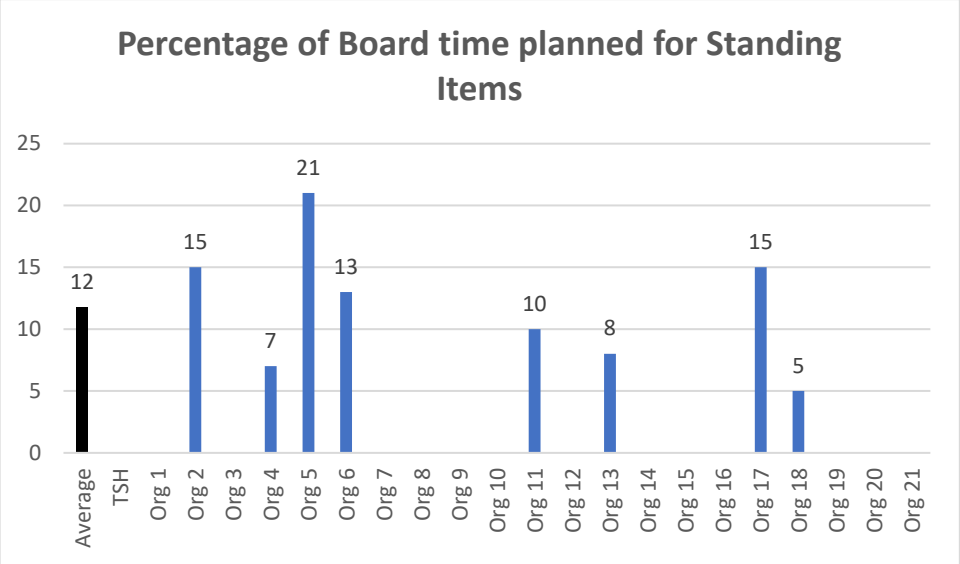
TSH does not use the classification for Monitoring or Assurance, although we have included those reports where the Agenda item states, 'For Discussion'.

Table 9



The high percentage of TSH's items for Information / Noting reflects the operational performance nature of some of the items being presented to the Board.

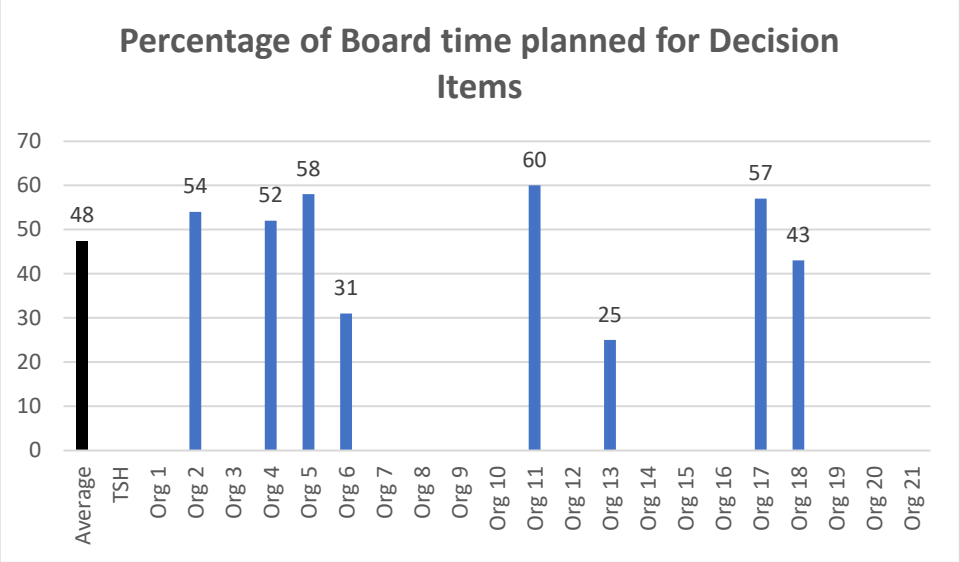
Table 10 (Information only)



TSH does not record the time allocated to specific Agenda items and so we were unable to benchmark this data however we have included the data set for information purposes only to provide insight into the average Percentage of Board time planned for Standing Items.

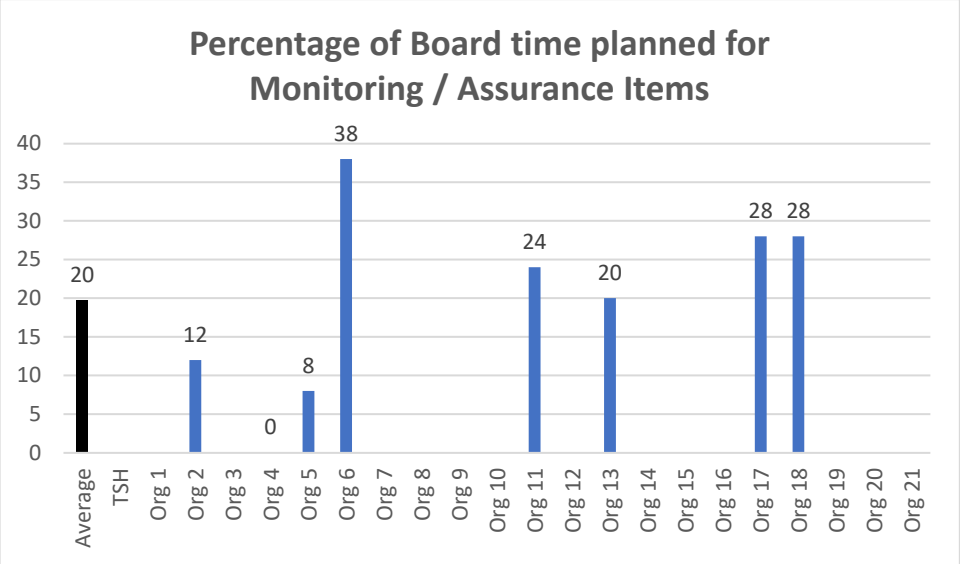
.

Table 11 (Information only)



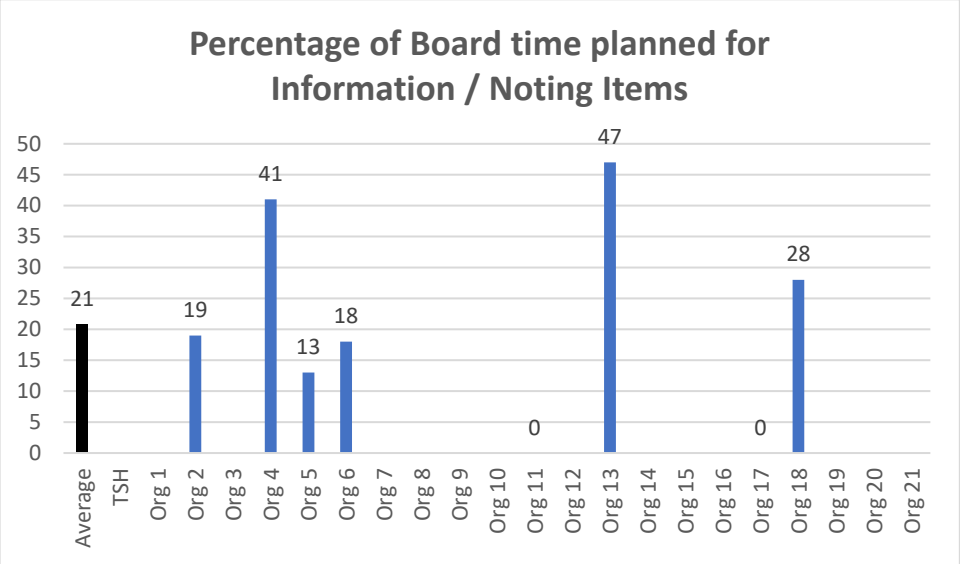
TSH does not record the time allocated to specific Agenda items and so we were unable to benchmark this data however we have included the data set for information purposes only to provide insight into the average Percentage of Board time planned for Decision Items.

Table 12 (Information only)



TSH does not record the time allocated to specific Agenda items and so we were unable to benchmark this data however we have included the data set for information purposes only to provide insight into the average Percentage of Board time planned for Monitoring / Assurance Items.

Table 13 (Information only)



TSH does not record the time allocated to specific Agenda items and so we were unable to benchmark this data however we have included the data set for information purposes only to provide insight into the average Percentage of Board time planned for Information / Noting Items.

APPENDIX B – EXAMPLE BOARD COVER REPORT

Meeting:	Board Meeting
Meeting Date:	Date of meeting
Report For:	Decision / Monitoring / Information / Discuss
Author(s):	Name and Job Title

REPORT TITLE

Purpose
Outline briefly the purpose of the report and include the business plan objective/s.

Decisions Required/ Recommendations
Key decisions the Board need to make.

Key Issues
What are the key issues or messages that you want to get across to the Board? What does the Board need to know? What are the financial and legal / regulatory implications? Are there any EDI / Customer / Stakeholder / Environmental implications?

Risks			
Risk Link to Key Strategic Risks	Inherent Risk	Mitigating Actions	Residual Risk
The key risks associated with the report that the Board members should be aware of	Risk rating without mitigation actions	The key mitigation actions that management are taking / propose to take to manage down the inherent risk associated with the report	Risk rating after mitigation actions

Background Information and Context
Outline in brief the background and context to the report and reference to previous reports (if appropriate) and where they were discussed and agreed outcome.

Options and Proposals
What are the options available to the Board and what are you (management) proposing?

Appendices
List all appendices as follows: Appendix 1 – name Appendix 2 – name or None

Author Contact Details:	
Contact No:	Email:

FOR FURTHER INFORMATION CONTACT

Marc Mazzucco
Partner

Third Floor
Centenary House
69 Wellington Street
Glasgow
G2 6HG

T 07711 036197
Marc.Mazzucco@rsmuk.com

rsmuk.com

Paper No. 20/70

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 October 2020
Agenda Reference:	Item No: 16
Sponsoring Director:	Director of Security, Estates and Facilities
Author(s):	Programme Director
Title of Report:	Perimeter Security and Enhanced Internal Security Systems: Project Oversight Board Annual Report
Purpose of Report:	For Decision

SITUATION

This is the Annual Report of the Perimeter Security and Enhanced Internal Security Systems Project Oversight Board (POB). Due to the timing of the project this report covers the period from contract agreement on 07 Feb 2020 to the end of August 2020. The next report should cover the period from September 2020 to April 2021, followed by a final report in early 2022 following completion of the project.

BACKGROUND

The POB was established to provide the required degree of assurance on the progression of the Perimeter Security and Enhanced Internal Security Systems Project in accordance with the Corporate Objectives of The State Hospitals Board for Scotland, and the appropriate statutory and mandatory standing orders and regulations. The Membership and Terms of Reference of the Project Board were reviewed in the early part of 2020 and the recast Project Oversight Board (POB) has held 6 meetings since that time; the reviewed POB Terms of Reference require the POB to submit an Annual Report on its activities to the State Hospitals Board.

ASSESSMENT

Since the beginning of the POB in its current format the POB has been assured that the project is meeting all necessary targets. The attached Annual Report meets the requirements of the POB Terms of Reference

RECOMMENDATION

That the Board **note** the annual report and **approve** the suggested annual reporting timescale

Author:
Doug Irwin
Programme Director
01555 842033

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives?	Maintain standards of governance
Workforce Implications	None
Financial Implications	None
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)	None
Assessment of Impact on Stakeholder Experience	None
Equality Impact Assessment	N/A
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	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

PERIMETER SECURITY & ENHANCED INTERNAL SECURITY SYSTEMS PROJECT

PROJECT OVERSIGHT BOARD ANNUAL REPORT

1 April 2020 – 31 August 2020

1 INTRODUCTION

The Report is submitted to meet the requirements within the Project Oversight Board's (the POB) Terms of Reference to submit an annual report of the work of the POB. The report also seeks to satisfy the Governance Statement requirement for the Committee to provide periodic reports to the Board in respect of Internal Control.

Due to the timing of the project this report covers the period from contract agreement on 07 Feb 2020 to the end of August 2020. The next report should cover the period from September 2020 to April 2021, followed by a final report in early 2022 following completion of the project.

2 THE PROJECT

The history of the project is well known to The Board; following difficulties in procurement of the project, a tender for the required works was awarded in early February 2020 to Stanley Security Systems Limited, who began work on site at the start of April 2020.

3 MEMBERSHIP AND ROLE OF THE COMMITTEE

Project Oversight Board Membership:

Gary Jenkins:	Chief Executive Officer (Co-Chair)
David Walker:	Director of Security, Estates and Facilities (Co-Chair)
Robin McNaught:	Finance and Performance Management Director
Mark Richards:	Director of Nursing and AHPs
Doug Irwin:	Project Director
Tom Hair:	Employee Director
Bill Sinclair:	Scottish Prison Service

Project Oversight Board Role:

The POB Terms of Reference (Appendix 1) require the POB to "provide the required degree of assurance on the progression of the Perimeter Security and Enhanced Internal Security Systems Project in accordance with the Corporate Objectives of The State Hospitals Board for Scotland, and the appropriate statutory and mandatory standing orders and regulations."

3 REVIEW OF THE WORK OF THE COMMITTEE

The POB meets monthly and considers progress reports from the Programme Manager, Project Manager / Lead Advisor and the Contractor. Reports and discussions cover relevant:

- Programme Issues
- Financial Issues
- Quality Issues
- Contractual Issues & contractor performance
- Project Risks
- Change Control

The POB has approved a work plan covering all aspects of the project through to benefits realisation after project conclusion (Appendix 2).

A strategic project risk register is maintained by the Project Manager on behalf of the Programme Director. All risks are reviewed at the monthly internal Operational Team Review and, when necessary, risk reduction meetings are called, if necessary at short notice, to deal with any newly arising risks. The Risk Register is a standing item on the agenda of the Project Oversight Board. At the time of writing two risks are scored as “high” risks; these relate to any increase in costs affecting project affordability and to the impact of COVID19. An operational Risk Register shared with SSSL is reviewed at each Project Team meeting and any risks identified through that process can, if necessary, be raised for inclusion on the strategic risk register.

Since a revision of the POB at the early part of the year the POB has met on 6 occasions, with a slight interruption to the schedule in order to accommodate the impact of the COVID outbreak.

4 REPORTING ARRANGEMENTS

The POB reports to each meeting of the State Hospitals Board via a summary project report by the Security, Estates and Facilities Director. In addition the POB submits an Annual Report to the State Hospitals Board in October.

5 PROJECT PROGRESS

5.1 Since contract agreement in February the Contractor has:

Set up a work site at TSH
Recruited a lead subcontractor to supervise delivery
Produced a works programme that includes:

- Procurement
- Surveys
- Risk Assessment and Method Statements for each works package
- Detailed Designs and Design Acceptance for each works package
- Cause and Effect planning
- Works on site
- Factory Acceptance Testing setup, programming testing and delivery
- Site acceptance Testing

Undertaken various other works on and off site as detailed below

5.2 Works undertaken on site to date:

Fibre installation across the site
CCTV installation in Skye Centre, Arran 3, Arran 2, Arran Hub and the Tribunal building
Outer perimeter camera column foundations and “moling” to the inner perimeter

5.3 Works undertaken off site to date:

Fit out of Factory Acceptance Testing facility
Installation of equipment (incomplete)
Programming of equipment (incomplete)

5.4 Works to be undertaken September 2020 to October 2021

- Completion of Clinical Area CCTV installation
- Perimeter CCTV replacement and installation
- Grounds CCTV installation
- Car Park CCTV installation
- Car Park and external are security improvements
    - Automatic Number Plate Recognition
    - Substation detection
    - Reception detection
    - Hostile Vehicle Mitigation
- Creation of Contingency Gate airlock
- Replacement / refresh of perimeter detection systems
- Painting and civil works to fence
- PAA system upgrade
- Radio system upgrade
- Security Control Room upgrade
- Access Control System upgrade
- Security Management System integration
- Factory Acceptance Testing
- Site Acceptance Testing

The progress against the programme is closely monitored by the Project Oversight Board and any issues will be raised with the Board in the monthly progress report from the Security, Estates and Facilities

6 CONCLUSION

Based on the work that it has undertaken, the Committee has met in line with its Terms of Reference, has fulfilled its remit and is satisfied that controls are adequate to ensure that the Board can achieve its objectives.

The State Hospitals Board for Scotland

Perimeter Security and Enhanced Internal Security Systems Project

Project Oversight Board - Terms of Reference

1. Purpose

The NHS Board has established a Project Oversight Board to provide the required degree of assurance on the progression of the Perimeter Security and Enhanced Internal Security Systems Project in accordance with the Corporate Objectives of The State Hospitals Board for Scotland, and the appropriate statutory and mandatory standing orders and regulations.

The Project Oversight Board (POB) will provide oversight and assurance, and make recommendations to the NHS Board in line with its remit.

2. Membership

Members:

Gary Jenkins:	Chief Executive Officer (Co-Chair)
David Walker:	Director of Security, Estates and Facilities (Co-Chair)
Robin McNaught:	Finance and Performance Management Director
Mark Richards:	Director of Nursing and AHPs
Doug Irwin:	Project Director
Tom Hair:	Employee Director
Bill Sinclair:	Scottish Prison Service

In Attendance:

Wesley Bathgate:	Senior Project Manager, Thomson Gray
Derek McDonald:	Security Advisor, D4
Kenny Andress:	Head of Estates and Facilities
Mary Frame:	Procurement Manager

The NHS Board Chair is not a member of the POB, but may attend any meetings of the POB.

3. Reporting Arrangements

The POB will report to the NHS Board following each meeting – this will be through the submission of the approved Minutes as well as a summary report of the key issues.

The POB will submit an Annual Report to the NHS Board, in June, and this will include: the name of the POB, membership and attendees and officer support, the frequency and dates of meetings, the activities of the POB during the year, any matters of concerns to the POB; confirmation that the POB has fulfilled its remit and of the adequacy and effectiveness of internal controls.

The POB will undertake an Annual Workplan aligned with the Project programme and this will be submitted with the Annual Report.

The POB will undertake an annual review of the Terms of Reference. If this review results in amendment, the revised Terms of reference should be submitted to the NHS Board for endorsement.

4. Key Responsibilities

1. To endorse the scope of the Project, and the benefits to be realised in development, including the clinical service delivery model of the NHS Board.
2. To ensure that the completed facilities are delivered on programme, within budget and are compliant with the NHS Board's corporate objectives and requirements.
3. To ensure that the resources required to deliver the project are available and committed.
4. To ensure appropriate governance through the procurement process and through the Capital Investment Group at Scottish Government.
5. To assure that the project remains within the framework of the overall project strategy, scope, budget and programme as set out in the business case.
6. To review and report changes to the scope of the project e.g. time, cost, quality, to the NHS Board.
7. To promote financial governance and monies and report the adherence within affordability parameter set out by Scottish Government and the NHS Board.
8. To review the risk management plan, ensuring all risks are identified; that appropriate mitigation strategies are actively applied, managed and escalated as necessary, providing assurance to the NHS Board that all risks are being effectively managed.
9. To ensure that staff, partners and service end users are fully engaged in designing operating policies that inform the detailed design and overall procedures that will apply, ensuring that the facilities are service led, not building led.
10. To ensure that communication planning enables the appropriate involvement of and communication with all stakeholders, internal and external, throughout the project.
11. To ensure that appropriate systems of assurance are in place for the functional commissioning of the facilities and operation of the project systems.

5. Conduct of Business

Meetings:

The POB will normally meet monthly. The Co-Chairs may convene additional meetings or change the frequency of meetings as deemed necessary.

The POB may ask any or all of those who attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

The NHS Board may ask the POB to convene further meetings to discuss particular issues on which they want the POB's advice.

Quorum:

A minimum of four members of the POB will be present for the meeting to be deemed quorate.

In the event of a meeting becoming inquorate once convened, the Co-Chairs may elect to continue receiving papers and to allow those present to ask questions and discuss particular matters. The minute should state the point at which the meeting became inquorate but notes of any discussion can be included. Every item discussed and noted in this way will be brought to the next meeting of the POB, under matters arising, for ratification.

Absence of Co-Chairs:
In the event of the Co-Chairs being absent, another member can be designated the chair for the meeting, and this should normally be arranged by the Co-Chairs in advance of the meeting.

Agenda, Papers, Workplan and Minutes:
The POB should have a workplan for the year mapped to the remit of the POB.

The Co-Chairs will set the agenda.

Papers should be submitted to the Project Administrator at least seven working days prior to the meeting. The finalised agenda and papers will be issued to members at least three working days before the date of each meeting.

The meeting will be minuted and will record decisions, actions and responsibilities, actions against identified risks and follow up. Minutes will be submitted to the NHS Board, and published on The State Hospital website as part of the NHS Board papers.

Annual Report:
The POB will prepare and submit an Annual report to the NHS Board in June each year, and this should include:

- The name of the POB, the Co-Chairs, Membership, Executive Leads and Officer supports.
- Frequency, Dates of meetings and attendance.
- The activities of the POB over the year, including confirmation of delivery of the workplan and review of the terms of reference. Should the terms of reference be revised, these should be submitted to the NHS Board for approval.
- Improvements that have been overseen by the POB
- Any areas of concern to the POIB, including Risk.
- Confirmation that the POB has fulfilled its remit, and of the adequacy and effectiveness of internal control.

6. Information Requirements

For each meeting the POB will be provided with a report which will include as a minimum:

Progress Update (business, design and construction)
Current status against key programme elements
Current status against cost planning
Project Risk Register with description of mitigating actions

Communications planning with internal and external stakeholders
7. Executive Leads
The Chief Executive Officer and the Director of Security, Estates and Facilities will co-chair the POB. Accountability for ensuring the longer term security needs of The State Hospital are aligned to the Director of Security, Estates and Facilities, within the project governance structure. Accountability for the financial aspects of the project are aligned to the Finance and Performance Management Director.
8. Access
POB Members will have free and confidential access to the Co-Chairs of the POB.
9. Rights
The POB may procure specialist advice at the expense of the organisation, subject to budgets agreed by the NHS Board or the Chief Executive Officer as Accountable Officer.

Author(S):	Margaret Smith, Board Secretary
Ratified by The State Hospitals Board for Scotland:	July 2020
Review Date:	June 2021

THE STATE HOSPITALS BOARD FOR SCOTLAND: PROJECT OVERSIGHT BOARD

AREA OF REVIEW	August 2020	September 2020	October 2020	November 2020	December 2020	January 2021	February 2021	March 2021
STANDING ITEMS	• Minutes of Previous Meeting • Action Tracker • Update Report from Programme Director • Monthly Cost Report	• Minutes of Previous Meeting • Action Tracker • Update Report from Programme Director • Monthly Cost Report	• Minutes of Previous Meeting • Action Tracker • Update Report from Programme Director • Monthly Cost Report	• Minutes of Previous Meeting • Action Tracker • Update Report from Programme Director • Monthly Cost Report	• Minutes of Previous Meeting • Action Tracker • Update Report from Programme Director • Monthly Cost Report	• Minutes of Previous Meeting • Action Tracker • Update Report from Programme Director • Monthly Cost Report	• Minutes of Previous Meeting • Action Tracker • Update Report from Programme Director • Monthly Cost Report	• Minutes of Previous Meeting • Action Tracker • Update Report from Programme Director • Monthly Cost Report
FOR INFORMATION	• Lead Advisor Dashboard Report 23 • QS Construction Cost Report 4 • Stanley Progress Report 4 • OTRM 26 Minutes • PT 7 Minutes • Project Risk Register	• Lead Advisor Dashboard Report 24 • QS Construction Cost Report 5 • Stanley Progress Report 5 • OTRM 27 Minutes • PT 8 Minutes • Project Risk Register	• Lead Advisor Dashboard Report 25 • QS Construction Cost Report 6 • Stanley Progress Report 6 • OTRM 28 Minutes • PT 9 Minutes • Project Risk Register	• Lead Advisor Dashboard Report 26 • QS Construction Cost Report 7 • Stanley Progress Report 7 • OTRM 29 Minutes • PT 10 Minutes • Project Risk Register	• Lead Advisor Dashboard Report 27 • QS Construction Cost Report 8 • Stanley Progress Report 8 • OTRM 30 Minutes • PT 11 Minutes • Project Risk Register	• Lead Advisor Dashboard Report 28 • QS Construction Cost Report 9 • Stanley Progress Report 9 • OTRM 31 Minutes • PT 12 Minutes • Project Risk Register	• Lead Advisor Dashboard Report 29 • QS Construction Cost Report 10 • Stanley Progress Report 10 • OTRM 32 Minutes • PT 13 Minutes • Project Risk Register	• Lead Advisor Dashboard Report 30 • QS Construction Cost Report 11 • Stanley Progress Report 11 • OTRM 33 Minutes • PT 14 Minutes • Project Risk Register
MILESTONES:								
COMMISSIONING OF SYSTEMS				Completion of FAT				
MOVEMENT OF EQUIPMENT					FAT equipment delivery			
OTHER ISSUES		Annual Report to TSH Board	Completion of "Cause and Effect" design	Completion of Design process				

AREA OF REVIEW	April 2021	May 2021	June 2021	July 2021	August 2021	September 2021	October 2021	November 2021
STANDING ITEMS	• Minutes of Previous Meeting • Action Tracker • Update Report from Programme Director • Monthly Cost Report	• Minutes of Previous Meeting • Action Tracker • Update Report from Programme Director • Monthly Cost Report	• Minutes of Previous Meeting • Action Tracker • Update Report from Programme Director • Monthly Cost Report	• Minutes of Previous Meeting • Action Tracker • Update Report from Programme Director • Monthly Cost Report	• Minutes of Previous Meeting • Action Tracker • Update Report from Programme Director • Monthly Cost Report	• Minutes of Previous Meeting • Action Tracker • Update Report from Programme Director • Monthly Cost Report	• Minutes of Previous Meeting • Action Tracker • Update Report from Programme Director • Monthly Cost Report	• Minutes of Previous Meeting • Action Tracker • Update Report from Programme Director • Monthly Cost Report
FOR INFORMATION	• Lead Advisor Dashboard Report 31 • QS Construction Cost Report 12 • Stanley Progress Report 12 • OTRM 34 Minutes • PT 15 Minutes • Project Risk Register	• Lead Advisor Dashboard Report 32 • QS Construction Cost Report 13 • Stanley Progress Report 13 • OTRM 35 Minutes • PT 16 Minutes • Project Risk Register	• Lead Advisor Dashboard Report 33 • QS Construction Cost Report 14 • Stanley Progress Report 14 • OTRM 36 Minutes • PT 17 Minutes • Project Risk Register	• Lead Advisor Dashboard Report 34 • QS Construction Cost Report 15 • Stanley Progress Report 15 • OTRM 37 Minutes • PT 18 Minutes • Project Risk Register	• Lead Advisor Dashboard Report 35 • QS Construction Cost Report 16 • Stanley Progress Report 16 • OTRM 38 Minutes • PT 19 Minutes • Project Risk Register	• Lead Advisor Dashboard Report 36 • QS Construction Cost Report 17 • Stanley Progress Report 17 • OTRM 39 Minutes • PT 20 Minutes • Project Risk Register	• Lead Advisor Dashboard Report 38 • QS Construction Cost Report 18 • Stanley Progress Report 18 • OTRM 40 Minutes • PT 21 Minutes • Project Risk Register	• Lead Advisor Dashboard Report 39 • QS Construction Cost Report 19 • Stanley Progress Report 19 • OTRM 41 Minutes • PT 22 Minutes • Project Risk Register
MILESTONES:								
COMMISSIONING OF SYSTEMS						Start of Site Acceptance Testing	Completion of Site Acceptance Testing	Conclusion of Commissioning
MOVEMENT OF EQUIPMENT								
OTHER ISSUES						Annual Report to TSH Board	Post Project Evaluation / Benefits Evaluation plan	Handover

APPROVED Minutes of the Project Oversight Board Meeting held on Thursday 27 August 2020 at 2.00pm via Microsoft Teams

Present:

Kenny Andress	*Head of Estates and Facilities*
Tom Hair	*Employee Director*
Doug Irwin	*Programme Director*
Robin McNaught	*Finance & Performance Management Director*
Mark Richards	*Director of Nursing and AHP*
Bill Sinclair	*Scottish Prison Service*
David Walker	Director of Security, Estates and Facilities

In Attendance:

Fiona Higgins	*PA to Finance and Performance Management Director* ***(Minutes)***

1 APOLOGIES AND INTRODUCTORY REMARKS

Apologies for absence were noted from Gary Jenkins.

David Walker chaired the meeting and welcomed those participating.

2 CONFLICT OF INTEREST,

There were no new conflicts of interest declared.

Conflict noted previously:
Gary Jenkins role as Chair of The Health Care and Custody Network

3a MINUTES OF PREVIOUS MEETING AND ACTION TRACKER

Members **approved** the minutes of the meeting held on 16 July 2020 following a minor amendment on page one, item 3b – Infection Control.

3b ACTION TRACKER

1 Decantation

Action complete and closed.

2 Infection Control

Action complete, however to remain on agenda as individual HAI Scribes required for each area.

3 Resources

- Estates Admin - recruitment complete
- Project Admin - preferred candidate identified, pre employment checks underway
- Security Role – advert closes 28 August, update from Stephen Fleming at next meeting.

Item to remain on tracker until all candidates are in role.

4 Anticipated Project Cost Report – Clarification re Staffing Costs

Robin McNaught advised that Alan Morrison of the Scottish Government has been kept informed of project costs/spend and assured the Board that additional approvals are not formally issued when a project is underway, rather the initial project approval stands.

Action complete and closed.

5 Early Warning Notices
Doug Irwin advised that he would revisit this action on conclusion of the Design Process (end of October) to determine if escalation should be considered. Action to remain on action tracker.

6 Stanley Contractors – Covid 19 Weekly Testing
Mark Richards advised that he had provided comments to Doug Irwin in relation to the Stanley Guidance for Contractors Document. Doug Irwin informed members that the comments are being taken forward by Stanley, consideration is also being given to the provision of testing for contractors subject to a risk based criteria, where contractors working within a ward area may be tested, however those working outdoors outwith clinical area would not require testing.

Members were assured that the concerns raised have been addressed and agreed to close off the action as complete.

7 Draft Workplan
Action complete and closed.

STANDING ITEMS
3 PROGRAMME DIRECTOR UPDATE REPORT
Members received and noted an update from Doug Irwin, Programme Director, the key points from the report were highlighted as detailed below.

Significant Issues
Programme and Potential for Delay
Members noted that Revision 12 of the Programme is expected to be submitted to the Hospital Project Team on Tuesday. Challenges and delays with design packages have mainly been in relation to quality control issues. In order to address this Stanley have employed additional resources, including further engagement with the Hospital Project Team.

Site Supervision
Members noted the breaches of the Risk Assessment and Method Statement (RAMS) and were assured that these have been addressed and work has resumed in line with approved RAMS.

Camera Placement
Following the incorrect placement of cameras as a result of a discrepancy within the plans provided to Stanley a change control cost is expected, Thomson Gray are currently reviewing the estimated costs provided by Stanley.

Access Control System Visitor Module
Members noted the option to purchase a Visitor Administration Module as part of the Access Control System, this would address the out of date and unsupported system which is currently in use. Costing have been requested to allow a decision to be made.

Accuracy of Information Supplied to Stanley
Members noted that several inaccuracies within drawings issued to Stanley have been noted. For future proofing a topographic survey of the site will be undertaken.

Payment
Payment 5 is complete.

Complete work
The tubestile installation and Arran 3 work is now complete

Early Warning Notices (EWN)
Members noted the tables which detailed the early warning notices recorded for Contractor, Project Manager and Advisor. No issues of concern other than those in relation to the ongoing Contractor Design Package delays were highlighted to members.

Compensation Events
None

Site Issues
RAMS not being followed as advised under significant issues

Planned on Site Works and Off Site Works
A list of the works planned to commence up to 13 September 2020, both on and off site were detailed within the report and advised to members.

Risk
Members noted that Thomson Gray have updated the Risk Register to reflect the NHS matrix and this showed that there were no red risks.

The Project Bank Risk has been removed and the Brexit Risk now sits with Stanley.

The Risk Register is reviewed monthly at the Operational Team Review Meeting.

Members noted the content of the update report.

4 PROJECT UPDATE REPORTS
Project Update Reports presented for information, key points detailed in the Programme Director Report presented at item 3.

5 TSH MONTHLY COST REPORT
Members received and noted the monthly Cost Report, presented by Doug Irwin, who advised that there was £0.5m below target spend due to equipment / programme delays, this will be reflected in the new programme

Members noted the cost report as presented.

6 ANY OTHER BUSINESS
Draft Workplan
Members approved the Draft Workplan to November 2021.

7 **DATE AND TIME OF NEXT MEETING**
The next meeting is scheduled to take place on Thursday17 September 2020 at 2.00pm using Microsoft Teams *(meeting postponed to 15 October 2020)*

The date of the next informal catch up meeting is Thursday 3 September 2020 at 2.00pm using Microsoft Teams.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 October 2020
Agenda Reference:	Item No: 17
Sponsoring Director:	Finance and Performance Management Director
Author(s):	Deputy Director of Finance
Title of Report:	Financial Position as at 30 September 2020
Purpose of Report:	For Noting

1 SITUATION

The Board is asked to consider the Revenue and Capital Resources spending plans, and monitor financial outturn. This report provides information on the financial performance to 30 September 2020, which is also issued monthly to Scottish Government (SG) along with the statutory financial reporting template. It is also reported to the Board, Senior Management Team and Partnership Forum. There have been alterations to this in 2020/21 due to the Covid crisis, although timings are now starting to return to schedule through the SG and Board remobilisation plans.

2 BACKGROUND

Scottish Government are provided with an annual Operational Plan and 3-year financial forecast template, the draft version of which was submitted, reviewed and agreed but – due to Covid-19 – this process has now been replaced by the Board Remobilisation Plans. The next iteration of this Plan was sent to Scottish Government ("SG") for 14 August 2020 – covering the period August 2020-March 2021.

Having been delayed by the Covid-19 crisis, monthly financial performance reporting to SG is now resuming at the end of August 2020. In the meantime, regular returns highlighting specific Covid-related costs have been submitted, with a return for Quarter 1 to 30 June sent in August specifically to address SG's assessment of expected Board settlement allocations. Quarter 1 reviews by SG have been undertaken with Boards notified of levels of reimbursement of Covid costs in early October.

The base budgets have been established and in line with balance are set on achieving £1.322m efficiency savings, as referred to in the table in section 4. £0.085m has been recognised over and above this in the base budgets. The savings are lower than last year is because additional income has been set as £0.500m for exceptional circumstance patients.

The annual budget of £39.805m is primarily the Scottish Government Revenue Resource Limit allocation.

3 ASSESSMENT

3.1 Revenue Resource Limit Outturn

The Board is reporting an under spend of £0.232m to 30 September 2020. Please refer to 3.3 for more detail.

Of the unidentified £0.421m savings, this is being phased monthly, with £0.210m offset to date with vacancy savings.

3.2 Key financial pressures / potential benefits.

2020/21 PRESSURES	Risk	annual estimate £'k	Included in Reserves
Clinical Model Review	High	50	Y
Office 365	High	250	N
2020/21 BENEFITS			
Travel underspend re covid (excl. patients travel) ytd		26	Apr-Sept
New Accruals Mar 20 - reversal 20/21 - to be reviewed			

Covid-19
There are additional costs now incurred which are regarded as being specifically due to the Covid-19 crisis, ongoing through 2020/21 as monthly recurring costs as the Hospital operates under new ways of working.
These costs have been formally reported to the Scottish Government's Covid-19 Health Finance team within the Health Finance and Infrastructure Directorate, and feedback / discussion has followed directly on these reports.
SG have made the initial allocation to Boards via the September allocation letter, which is detailed in the Covid finance paper presented to the Board.

Clinical Model review
The review of the clinical model identified potential recurring savings in ward nursing - values to be confirmed – which would have been beneficial from early 2020/21 and monitored as part of the overall evaluation of the model. However this is on hold due to Covid. There are, however, potential unidentified 2020/21 costs yet to be determined subject to the steps required to prepare for the implementation of the model e.g. Estates costs – now principally deferred and likely to be recognised in 2021/22.

Office 365
NHS Scotland are directing all Boards to the implementation of Office365 in 2020. This requires input from all directorates and much staff commitment. While the plan was originally scheduled for early 2020, it is now underway and any potential additional costs will be evaluated and, should additional funding be required to meet the demands of this, a specific business case will be raised.

Travel
Travel is underspent, due to reduced demand as a result of staff working remotely. However, this is offset by the higher demands on teleconferencing which have resulted in increased call charges, recognised through the Covid financial returns.

Accruals
These will be reassessed as part of the mid-year Finance review.

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 6	Budget WTE	Actual WTE
Nursing And Ahp's	20,134	10,211	10,059	152	379.10	388.83
Security And Facilities	5,913	2,987	2,922	65	118.64	113.41
Medical	3,975	1,988	1,804	184	37.13	28.99
Chief Exec	1,852	928	936	(9)	22.27	24.47
Human Resources Directorate	836	418	395	23	13.45	11.78
Finance	3,049	1,525	1,443	82	38.39	35.55
Cap Charges	2,857	1,429	1,418	10	0.00	
Misc Income	(600)	(300)	(264)	(36)	0.00	0.00
Central Reserves	1,788	(210)	30	(240)	0.00	0.00
	39,805	**18,976**	**18,744**	**232**	**608.98**	**603.03**

Highlights:

Nursing & AHPs; Security & Facilities - see further details below.

Medical – Underspend from vacancies in Psychology, plus the benefit of some staff having worked reduced hours. Medical staffing is also underspent due to Maternity Leave and timing of increments.

HR – Underspend from vacancies.

Learning Centre – Very little of the training budget has been utilised to date – this is under review for confirmation of the requirements and timings for the remainder of the year.

Finance – Underspend from vacancies.

Research – Reduced spend in the year to date – under review for the requirements of the remainder of the year.

Misc. Income – Now recognises £0.500m annual budget for Exceptional Circumstances Patients.

Central reserves
Savings unidentified are now partly phased year to date, with some still remaining in period 12. Other reserves are earmarked for pending developments.

3.3.1 Nursing & AHPs

Nursing And Ahp's	Annual Budget £'k	Year to Date Budget £'k	Year to date Actuals £'k	YTD Variance (budget less actuals) for period 5	Budget WTE	Actual WTE
Advocacy	147	61	60	2	0.00	
AHPs & Dietetics & SLAs	687	286	268	18	13.33	12.94
Hub & Cluster Admin & Clinical Ops	803	334	313	22	23.17	19.78
NPD & Infection Control & Clin Gov	410	171	177	(6)	5.80	5.33
PCI & Pastoral	231	96	83	13	3.40	3.60
Skye Centre	1,680	700	662	38	38.33	33.57
Ward Nursing	15,889	6,620	6,620	0	295.07	322.36
	19,847	**8,270**	**8,183**	**87**	**379.10**	**397.58**

Ward Nursing

Student nurses recruited in early 2020/21 – funding has now been confirmed through the Covid allocation.

NPD – savings remain unidentified, together with the cost of a member of staff not seconded out due to Covid resulting in a charge against budgeted income.

Others – underspends mainly in connection with vacancies.

	2020/2021	Ward Nursing ledger spend analysis						Pool new students 12.00 wte's	cr > budget
Prior Year Variance £'k	Ledger Ward Nursing cumulative	Annual Budget £'k	In month / Year to Date Budget £'k	In month / Year to date Actuals £'k	YTD Variance (budget less actuals) £'k	Budget WTE	Actual WTE	Contracted / conditioned wte's	Diff in contracted less budget wte's
(65)	April 20	15,874	1,323	1,405	(82)	295.07	328.61	298.06	(2.99)
(58)	May 20	15,889	1,324	1,272	52	295.07	314.80	305.31	(10.24)
3	June 20	15,889	1,324	1,302	22	295.07	314.24	302.30	(7.23)
(1)	July 20 (PAIAW)	15,889	1,324	1,340	(16)	295.07	326.96	300.79	(5.72)
(6)	August 20	15,889	1,324	1,301	23	295.07	322.36	298.51	(3.44)
(8)	September 20	16,168	1,603	1,567	36	295.07	313.95	295.25	(0.18)
(134)	Cumulative YTD		8,222	8,187	35				

3.3.2 Security and Facilities

Security And Facilities	Annual Budget £'k	Year to Date Budget £'k	Year to date Actuals £'k	YTD Variance (budget less actuals) for period 6	Budget WTE	Actual WTE
Facilities	4,282	2,172	2,049	122	78.87	74.68
Security	1,631	816	871	(55)	39.77	38.73
Perimeter Security	0	0	2	(2)	0.00	0.00
	5,913	**2,987**	**2,922**	**65**	**118.64**	**113.41**

Facilities – Call charges have increased dramatically due to staff working from home. However, this is offset with vacancies, and significant under spends in utilities. We have now recognised the Covid allocation confirmed in early October, to address the earlier pressures.

Security – The overspend is due to changes in the staffing structure, for which a pending workforce review is expected to address this within the Directorate.

Perimeter Fence – While the main staff costs in this regard are being cross charged to capital as part of the FBC, overtime related to Security remains a revenue cost.

4 ASSESSMENT – SAVINGS

The following table is the savings set by Directorate, further discussions continue to address the unidentified savings balance of £0.421m, of which 1/12ths are now being phased year-to-date.

The vast majority of our savings are through vacancy management, which is treated as non-recurring.

Cumulative Savings	Savings - Annual Target	Achieved to date	(Still to be achieved) / over achieved	Memo - savings already in base
Directorate	**£'k**	**£'k**	**£'k**	**£'k**
Chief Executive	(143)	65	(78)	0
Finance	(49)	48	(1)	(30)
Nursing & AHP's	(315)	139	(176)	0
Human Resources	(15)	0	(15)	0
Medical	(144)	176	32	(55)
Security & Facilities	(235)	126	(109)	0
Unidentified (£210.5k phased ytd)	(421)	0	(421)	0
Total	**(1,322)**	**554**	**(767)**	**(85)**

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

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

National Boards Contribution

The eight National Boards (formerly Special Boards) continue to work towards joint efficiencies and collaborative working. With a challenging £15m collective savings target to be achieved per annum, there is pressure on each board to contribute towards any shortfall.

The level to which the Board agreed for 2019/20 remained at £0.220m, with 2020/21 at present committed at the same level – while there continues to be pressure on the collective boards due to the £15m not yet being fully identified.

5 CAPITAL RESOURCE LIMIT

The capital allocation anticipated from Scottish Government for the year is £0.269m, with a further £0.040m received September for Covid related spend.

Over and above this is the perimeter fence project allocation, this shows Year 1 of 2.

CAPITAL CRL AS AT SEPTEMBER 2020	ANNUAL PLAN £'k	YTD SPEND £'k
PERIMETER SECURITY		
STANLEY SECURITY SOLUTIONS LTD		3,654
SECURITY CONTRACTING SERVICES LTD		101
THOMSON GRAY LTD		129
TSH STAFFING APR & MAY 20		73
PERIMETER SECURITY TOTAL	**9,150**	**3,957**
CAPITAL		
IM&T		110
OTHER		12
COVID		0
CAPITAL	**309**	**123**

6 RECOMMENDATION

Revenue
Year-to-date position is £0.232m under spend.

Capital
While this is not currently scheduled evenly through the year, and the timing is being reviewed on this basis, a breakeven outturn is anticipated. Planned funding will be aligned to actual spend for monthly breakeven.

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

Author:
Moira Donoghue
Deputy Director of Finance
01555 842004

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/SMT/Partnership Forum Which groups were involved in contributing to the paper and recommendations.	Requested to board meetings as part of workplan
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.

Board Report 20/72

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 October 2020
Agenda Reference:	Item No: 18
Sponsoring Director:	Finance and Performance Management Director
Author(s):	Risk Management Team Leader
Title of Report:	Risk Management Annual Report 2019/20
Purpose of Report:	For Noting

1 SITUATION

This annual report provides the Board with details of the activity undertaken within the Risk Management department over period 1 April 2019 until 31 March 2020.

2 BACKGROUND.

The Risk Management Department is part of the Finance & Performance Directorate and is involved in a range of functions from the maintenance of risk registers, development and review of Resilience Plans, Incident Reporting and Enhanced Reviews, Health & Safety, Duty of Candour to the administration and management of claims and complaints.

The Audit Committee has overall responsibility for evaluating the system of internal control and corporate governance, including the risk management strategy and related policies and procedures. This report was discussed in full at Audit Committee on 8 October and content noted.

3 ASSESSMENT

Areas of Good Practice

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

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

Areas of good practice within the risk management department include:

- Continued development of the Corporate Risk Register with risk owners
- Progress made on resilience testing and plan updates.
- Pandemic Flu and Loss of Staff exercise undertaken in December 2019, plans updated thereafter, pre-covid.

Identified issues and potential solutions
Following our report of last year, we successfully recruited a Risk Management Facilitator in September 2019. Team resilience is currently a major issue with many functions being person dependant. Work is ongoing to improve departmental resilience.
SALUS Health and Safety sessions remain supporting the day to day management of health and safety arrangements and the workplace inspections/audits that also require to be undertaken.

Future areas of work and potential service developments
Recruitment is underway for part-time administrative support. This will help improve routine incident reporting and Datix administrative tasks. It is also hoped to assist with the reduction of Category 1/2 completion timescales.

Resilience priorities will be developed with the Security Director to ensure support for organisational resilience arrangements. This will include internal plan testing and training. Risk assessments have also been prepared in preparation for the withdrawal of the UK from the EU both locally via the Local Resilience Partnership and nationally via Scottish Government.

The next annual report will be submitted to the Audit Committee in September 2021.

4 RECOMMENDATION

The Board is invited to note the Risk Management Annual Report for the period 2019/20.

Author:
Nicola Watt
Risk Manager Team Leader
01555 842197

MONITORING FORM

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

THE STATE HOSPITALS BOARD FOR SCOTLAND

Risk Management Annual Report

2019-2020

Prepared by: Risk Management Facilitator
Risk Management Team Leader
Complaints/Claims Officer
Health & Safety Advisor
Approved by: Risk, Finance and Performance Group – (pending)

Contents

1. Risk Management Department

1.1 Introduction

The Risk Management Department is part of the Finance & Performance Directorate and is involved in a range of functions from the maintenance of risk registers, development and review of Resilience Plans, Incident Reporting and Enhanced Reviews, Health & Safety, Duty of Candour to the administration and management of claims and complaints.

1.2 Aims and Objectives

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

2. Governance

2.1 Committees/Groups

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

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

Supporting committees include:

- **Health, Safety and Welfare Committee** operates in partnership with staff, and plays a key role in monitoring and reviewing Health and Safety incidents, and policy implementation.
- The Committee reports issues to the Staff Governance Committee after each meeting and the minutes are circulated at the Audit Committee.
- **Resilience Committee** monitors and reviews progress on emergency and resilience plans, ensuring that core plans are in place, tested and reviewed, with the minutes being reported to the SMT.
- **Risk, Finance & Performance Group** was established in 2018 to oversee activities relating to risk, finance and performance across the Hospital and provide a governance and reporting mechanisms for these activities.
- **Patient Safety Group**, report prepared separately annually for Clinical Governance Committee.

3. Key Work Activities (2019-2020)

3.1 Risk Management

3.1.1 Corporate Risk Register (Appendix A)

A corporate risk is a potential or actual event that:

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

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

The hospital's risk register process was subject to internal audit in February 2019 with the final report presented in March 2019. 10 recommendations were made, 5 graded as low, 5 graded as medium. Work remains ongoing to progress completion.

3.1.2 Department/Local Risk Registers

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

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

3.2 Resilience

The Security Director is responsible for the management of Resilience within TSH and also chairs the Resilience Committee, which reports to the Risk, Finance and Performance Group. The Risk Management Department also produces an annual report for the Boards' Audit Committee.

3.2.1 Resilience Plans

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

Level 2 Incident Resilience Plans	Review Date	Incident Command Plans
Adverse Weather Conditions	October 2022	Part One Resilience and Emergency Planning Framework
Covid-19 Extreme Loss of Staff Plan	N/A	
E-Health Resilience Plan	June 2020	
Electrical Supply Failure	March 2020	Part Two Incident Command Manual - Section A: Guide for Incident Commanders - Section B: Checklists and Actions
Heating Systems Failure	September 2022	
JANUS Failure	October 2017	
Lack of Food Supplies	September 2022	
Laundry Provision Interruption	January 2020	
Lockdown of Site Plan	September 2020	Part Three

Loss of Control Room	October 2020	Level 2 Incident Resilience Plans
Loss of Patient Accommodation	September 2020	Part Four Level 3 Incident Emergency Plans - Siege - Escape - Fire - Intruder - Abscond
Loss of Staff	March 2023	
Pandemic Influenza Contingency Plan	January 2022	
Procurement Department	April 2020	
Shortage of Fuel Plan	September 2020	
Shortage of Pharmaceutical Supplies	May 2022	
Telecommunications Failure	September 2022	
Water Supply Failure	September 2022	

During 2019/20, the Risk Management Facilitator carried out a review of the TSH Level 2 Resilience Plans, with the findings being as follows:

- Covid-19 Extreme Loss of Staff Plan has been produced in light of the Covid-19 situation.
- 4 Level 2 Resilience Plans currently require to be reviewed
- 5 Level 2 Resilience Plans will require review during 2020.

A programme has been developed for 2019/20 to progress plan reviews and a testing schedule agreed.

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

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

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

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

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

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

	2015	2016	2017	2018	2019
Level 2	5	6	7	4	2
Level 3	0	2	0	0	0

Two Level 2 incidents were reported to the Resilience Committee during 2019, the details of which are as follows:

January
Fence detection failure. Patient's grounds access restricted to escorted only for a short time.

June
Major systems failure during the switch over to generator power for the monthly test, which resulted in a temporary "lockdown" of the site.

3.2.3 Training and Exercising

The Resilience Committee plan and review exercises in relation to resilience.

Support to Police Scotland
On one occasion The State Hospital has supported Police Scotland by supplying role players for the police national hostage and crisis negotiators course.

Incident Command – 'Golden Hour' training
One 'Golden Hour' session was delivered during 2019 to refresh existing staff and provide training to new staff fulfilling the role of senior clinical cover/security manager.

Level 2 exercises
To assist with the testing of Level 2 plans, as required by the NHS Standards for Organisational Resilience, notional exercises were undertaken in August for the following plans.

Heating system failure
Water supply failure
Loss of patient accommodation
Lack of food supplies
Minor amendments were made following this to ensure the plans remain fit for purpose.

A tabletop exercise was conducted in December 2019 which enacted Loss of Staff and Pandemic Flu plan. Suggestions and amendments were made and work is ongoing to update plans at the time of this report.

Level 3 plans
A meeting was held with Police Scotland, NHS Lanarkshire and South Lanarkshire Council, reviewing the multiagency plans for response to incidents within The State Hospital. This is ongoing at the time of this report.

An exercise was completed in January with Scottish Fire & Rescue Service (SFRS) with support from Police Scotland. This exercise allowed The State Hospital to test its incident command structure and response to a live fire situation. This also allowed SFRS to provide training and familiarise themselves with The State Hospital.

3.2.4 NHS Standards for Organisational Resilience

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

TSH's Lead for resilience (Security Director) has responsibility for ensuring these Standards are achieved and are monitored by TSH Resilience Committee.

The Resilience Committee Workplan for 2019 includes the development of an updated Resilience Standards Review Matrix to provide the Committee with re-assurance that TSH is demonstrating achievement of the Standards as a means of enhancing organisational resilience.

Response from 2018 submission highlighted:

- "Governance arrangements in place to oversee the Boards organisational resilience: A Resilience Committee, led by the Security Director, reports to the Senior Management Team (SMT). These arrangements also include submission of an annual report to the Board's Audit Committee. There is clear evidence of leadership and corporate ownership of the resilience agenda.

- Resilience Framework, which incorporates a Business Continuity Policy and BC Management, is in place. It is approved by the Resilience Committee and SMT.

- TSH has a robust plan and C3 arrangements in place for major incidents in line with its remit, and that its Pandemic Flu Plan is consistent with NHS Lanarkshire's and developed with their involvement.

- Plans are in place for severe weather. However, a Climate Risk and Vulnerability Assessment (CRVA) does not appear to have been undertaken. A CRVA would enable the Board to develop a better understanding of risks and vulnerabilities and adopt a strategic, coordinated approach to risk management / mitigation, infrastructure resilience and enhance business continuity planning. We recommend the use of the Climate Change Risk Assessment and Adaptation Planning Tool for Healthcare Assets (produced by NHS NSS) for this purpose. We expect to see progress on this in your next submission.

In summary, we recognise the considerable work being progressed on many fronts and on various levels both within the Board and with external agencies/partners to continuously enhance the Boards' organisational resilience."

2020 submission has been delayed due to Covid-19 but has addressed the issues raised.

3.3 Health & Safety

3.3.1 Control Book Audits

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

TSH currently operate circa 41 eCB's hosted on TSH's intranet which are audited within a 2-year cycle to ensure compliance with organisational and local policies and procedures including but not exclusive to recording, progressing and escalation of 'Health & Safety' issues and identification of new or emerging hazards and associated risks.

3.3.2 2019/20 Audit Summary

23 control books were identified for audit during the 2019/20 Control Book audit programme, of which 19 books were subject to audit and 4 books were deferred to the next audit programme to allow for re-organisation and training.
Resultant eCB audit scores were released by email to Control Book Holders with detailed feedback on audit findings and recommendations to improve quality of evidence within the eCB.

Department/	CB Audit	RA Audit
Main Kitchen & Staff Dining Room	72%	82%
Crafts - Skye Centre	90%	86%
Iona 3	81%	96%
Mull 1	82%	86%
Atrium - Skye Centre	72%	51%
Arran 1	68%	20%
Lewis 1	88%	97%
Iona 1	94%	92%
Arran 2	88%	87%
Sports & Fitness - Skye Centre	89%	92%
Lewis 2	89%	90%
Finance	87%	92%
Iona 2	89%	95%

Health Records	93%	100%
Procurement	97%	100%
Gardens - Skye Centre	48%	66%
e Health	92%	92%
Management Centre	70%	80%
Skye Centre Administration	87%	84%

3 Control books that failed to achieve an acceptable score on one or both aspects of audit were subject to unannounced desktop audits during Quarter 4. Resultant eCB audit scores were released by email to Control Book Holders with detailed feedback on audit findings.

Department/	CB Audit	RA Audit
Arran 1	67%	55%
Atrium - Skye Centre	84%	100%
Gardens - Skye Centre	75%	79%
Arran 1	84%	86%

Key Findings

- Limited implementation of previous audit feedback recommendations/advice
- Ongoing issues evidencing arrangements within areas of shared responsibility, for example Hub office accommodation, Family centre
- Lack of local orientation evidence for Students and Junior Doctors
- Lack of evidence of associated safe working procedures for foreseeable work activities out-with TSH settings
- Varied evidence of compliance with the requirement to identify and train DSE users and assess workstations
- Varied compliance with requirement to inspect Workplace/ Healthcare waste/ Fire safety arrangements on a quarterly basis

Recommendations

- Develop additional eCB section to facilitate evidencing safe working procedures for TSH staff working on non TSH premises
- Address a continued lack of evidence that various work specialties/disciplines based within shared areas have developed safety management systems, work procedures and associated risk assessments by introducing further department/ specialty Control Books
- Refresh focus on local action plan development when audit scores identify unsatisfactory standard of evidence available within the e-Control Book
- Confirm responsibilities for evidencing safe working arrangements within shared areas

Training Programme

Review H&S training programme with consideration to physical distancing.

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

RIDDOR requires employers to report incidents that 'arise out of or in connection with work resulting in: the death of any person; specified injury to any person or hospital treatment to non-employees; employee injuries resulting in over 7-day absence from work; dangerous occurrences and specified occupational diseases'. There has been a 64% decrease in reported RIDDOR incidents (-18) in comparison to 2018/19.

	Q1	Q2	Q3	Q4	2019/20	2018/19	2017/18
'Specified' Injuries*	0	0	1	0	**1**	**1**	**3**
Over 7 day lost time Injury	4	0	3	2	**9**	**27**	**34**
Total	4	0	4	2	**10**	**28**	**37**

3.4 Fire

Two fire alarm activations occurred during the year which required response from Scottish Fire & Rescue Service. On one occasion, this was due to a pipe bursting and causing steam to activate the fire alarms and the other was an activation of a fire alarm in the Skye Centre: the reason for this activation was suspected to be due to contamination of dust after a contractor was in testing the alarm.

3.5 Incident Reporting

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

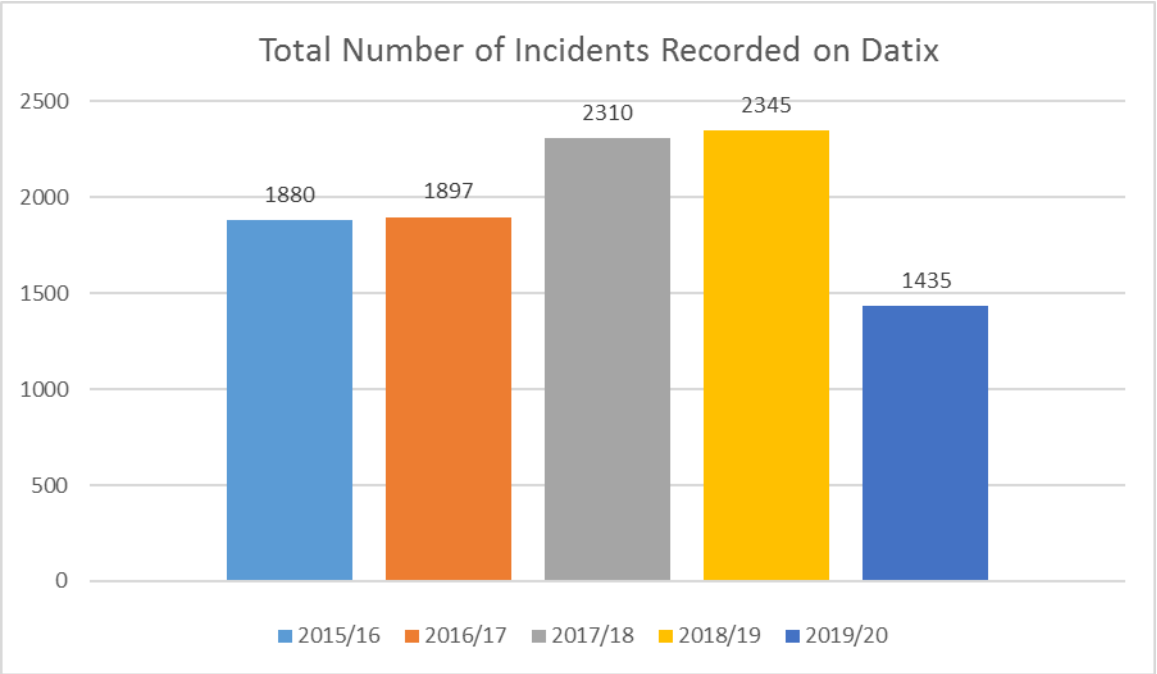
Each reported incident is investigated locally to ensure appropriate remedial and preventative steps have been taken. There are clear processes in place to identify incident trends or significant single incidents.

Datix classifies 7 overarching 'Type' of incident:

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

3.5.1 Datix Incidents

1435 incident reports were finally approved during 2019/20; a significant decrease in the number of incidents finally approved in 2018/19 (2345). The chart below shows the changes in the number of incidents reported within Datix over the last 5 years. The COM has worked closely with nursing staff to ensure a consistent approach to reporting adverse events. It was identified that previous events would constitute a nursing notes entry and thus not meeting the criteria for adverse events.



3.5.2 Incident 'Type' Trends over last 5 years

Incident Type	2015/16	2016/17	2017/18	2018/19	2019/20
Health & Safety	1238	974	1219	**1095**	**712**
Security	114	324	326	**396**	**138**
Direct Patient Care	213	269	270	**214**	**146**
Other	16	58	231	**426**	**219**
Equipment/Facilities/Property	194	166	175	**117**	**106**
Communication/Information Governance	74	70	66	**51**	**32**
Infection Control	31	36	23	**46**	**82**
Totals	**1880**	**1897**	**2310**	**2345**	**1435**
*Average Patient Population		114	109	107	106

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

In comparison with the figures for 2018/19, there has been a reduction in the number of incidents reported during 2019/20 related to: Health & Safety (35%); Security (65%); Direct Patient Care (32%); Other (49%); Equipment/Facilities/Property (9%); and Communication/Information Governance (37%). However, there has been an increase in the number of incidents related to Infection Control; from 46 to 82 (78%). The majority of these incidents are Clinical Waste (62 up from 29 the previous year) which now include incidents where the correct process for sending items to laundry was not followed.

3.5.3 Risk Assessment

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

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

The following table provides details of the number of “high” graded risk incidents reported since 2015/16, which are consistently low.

Year	No. of “High” Graded Risk Incidents
2015/16	4
2016/17	4
2017/18	3
2018/19	4
2019/20	1

The “High” graded risk incident reported in 2019/20 related to an article appearing in a national newspaper, the content of this article implies the information came from a leak by a State Hospital member of staff. As with previous information leaks, extensive efforts have been made to identify the the source of information to no avail. The Datix was investigated and CMT were notified of the incident agreeing no further action was required.

3.6 Enhanced Adverse Event Reviews

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

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

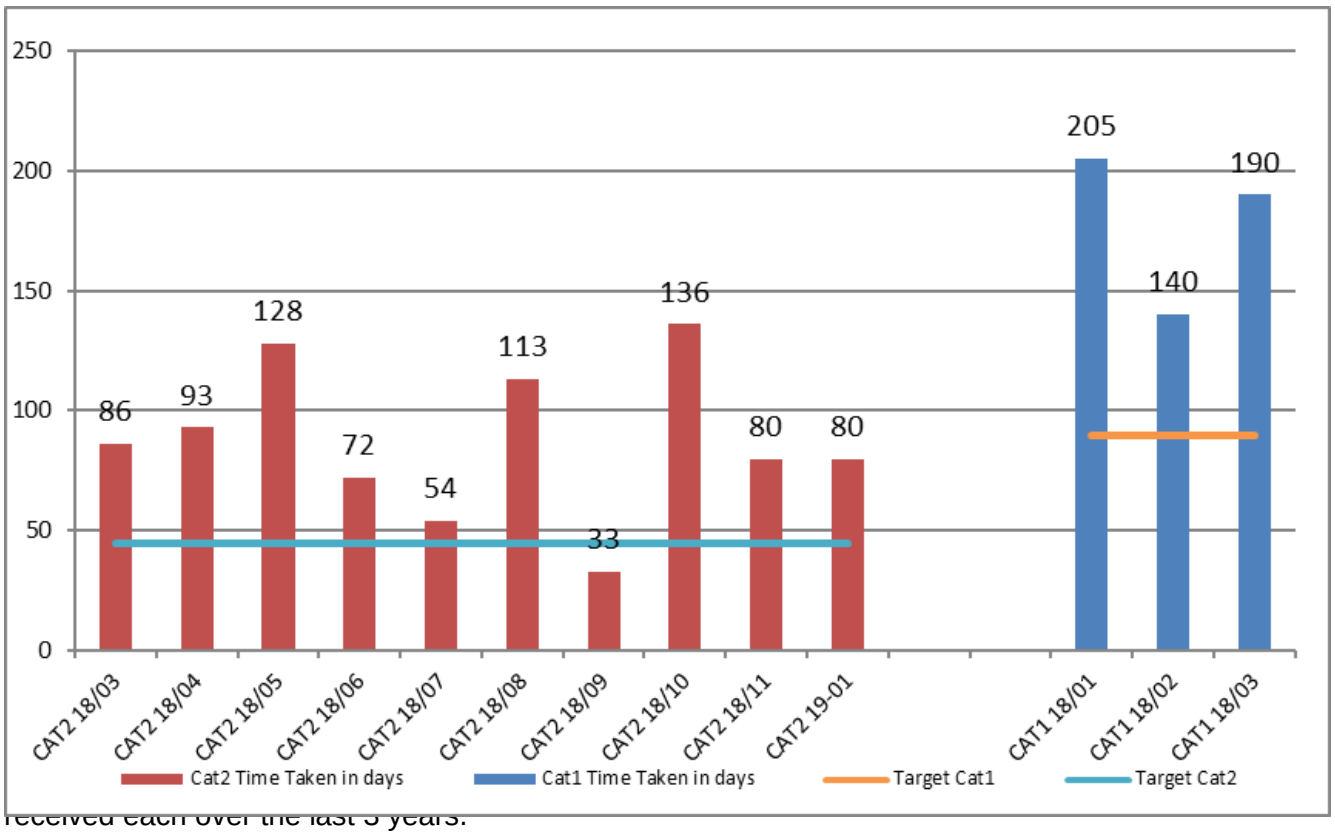
Level 2 Reviews are utilised for less serious incidents, whereby, an in-depth investigation is required to identify any learning points and to minimise the risk of the incident recurring. The Review is carried out by an appropriately trained member of the Risk Management Team, with the aim to establish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

There were no Category 1 reviews commissioned during 2019/20.

One Category 2 Review was commissioned during 2019/20 -

- Cat 2 19/01 – Sterilisation of Equipment

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



received each over the last 3 years.

Number of Complaints Received	2017/18	2018/19	2019/20
Total number **Received**	**121**	**61**	**52**
Average number of Patients throughout the year	109	107	106
Total number of **Complainants**	**56**	**35**	**21**

Due to the nature of the environment as a long-term health care setting, it is normal that stakeholders will inevitably submit more than one complaint during their time in TSH, which averages 6/7 years. In this year: Seven complainants made more than one complaint, compared to 35 complainants making one or more complaints last year.

3.7.1 Themes Emerging

The increase in the number of complaints in 2017/18 was expected with the introduction, promotion and embedding of the Complaints Handling Procedure raising the awareness of complaints and feedback across the hospital. In addition to this, changes to specific policies/practices in December 2018 contributed to the increase in the numbers received. The average number of complaints per year prior to the implementation of the Complaints Handling Procedure was 42.

Recurring issues this year related to *Staff Attitude/Behaviour/Conduct* (42%) and *Clinical Treatment* (25%) similar to previous years and accounting for 67% of all issues raised. Following a decrease last year, both issues showed an increase in this year.

3.7.2 Complaints Closed and Outcomes

A total of **43** complaints were closed this year. All complaints closed are categorised as either Upheld, Partially Upheld or Not Upheld. The table below shows the number of complaints closed at each stage this year and previous 2 years.

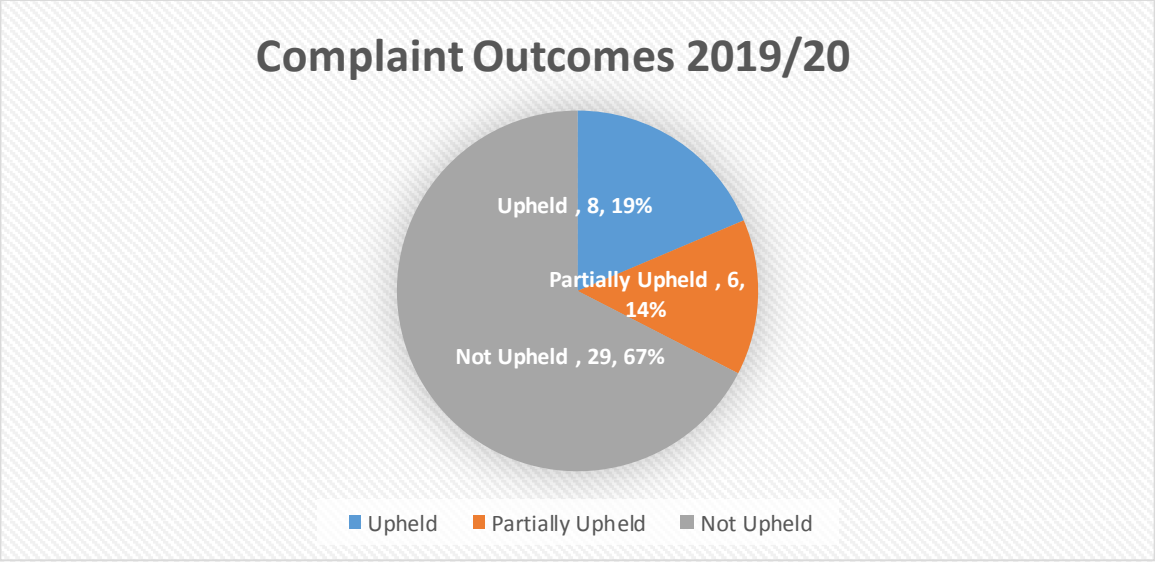
Total Number of **Complaints Closed**	**2017/18 Total**	**2081/19 Total**	**2019/20 Total**	**% of total Closed 2019/20**

Number closed at Stage 1	89	37	**30**	**70%**
Number closed at Stage 2	23	14	**7**	**16%**
Number closed after escalation to Stage 2	3	12	**6**	**14%**
Total Closed	**109**	**63**	**43**	**100%**

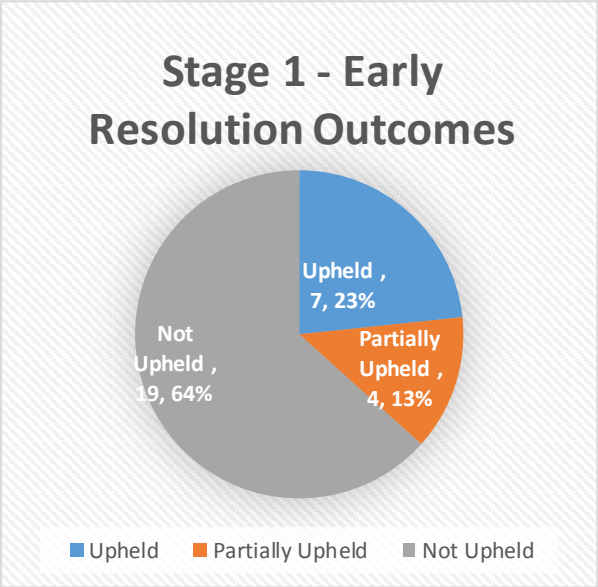
- 70% (30) of complaints received this year were resolved at Stage 1 this year with the remaining 30% (13) being investigated at Stage 2.

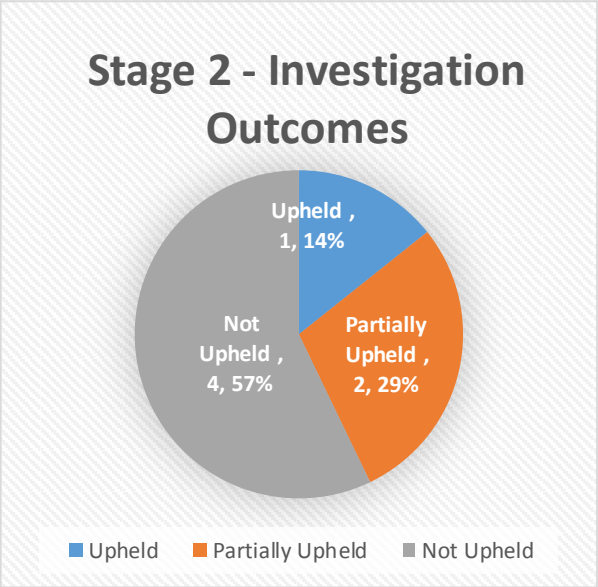
- 20% of complaints investigated at Stage 2 this year were escalated from Stage 1, in comparison to 46% in the previous year.

Outcomes of Complaints Closed	**2017/18 Total**	**2081/19 Total**	**2019/20 Total**	**As % of all closed 2019/20**
Upheld	51	31	**8**	**19%**
Partially Upheld	12	3	**6**	**14%**
Not Upheld	46	29	**29**	**67%**
Total	**109**	**63**	**43**	**100%**



Complaint Outcomes at each Stage 2019/20





This is the Outcomes of all complaints closed at Stage 2

3.7.3. Response Times

The Hospital continues to adhere to the CHP guidelines with the target for resolving complaints locally within 5 working days and completing investigations within 20 working days. The table below shows the average number of days taken to respond to complaints over the last 3 years.

Average Response Times	**2017/18**	**2018/19**	**2019/20**
Average number of days taken to resolve a complaint at Stage 1	**3**	**3**	**3**
Average Number of days taken to respond to a complaint at Stage 2	**15**	**13**	**18**
Average Number of days taken to respond after escalation to Stage 2	**14**	**17.5**	**20**

Complaints closed in full within timescales	**2017/18**	**2018/19**	**2019/20**
Number of complaints closed at Stage 1 within 5 working days	79	32	**29**
as % of the total number of Stage 1 complaints closed this year **(30)**	88%	89%	**97%**
Number of complaints closed at Stage 2 within 20 working days	27	22	**8**
as % of the total number of Stage 2 complaints closed this year **(13)**	93%	85%	**62%**

3.7.4. Focus on Quality

Whilst always being mindful of the target response times, importance is placed on ensuring that the response fully addresses all of the issues raised. The Board are committed to ensuring that the focus is about the learning opportunities that arise from complaints, therefore on occasion an extension has been required to allow a more comprehensive response to be provided. To ensure compliance, all complaints where the response time exceeds CHP guidelines are reported to and monitored through our governance groups

Extensions Authorised	**Total No**
Number of Stage 1 complaints where an extension was authorised	**1**
as % of the total number of Stage 1 complaints closed (30)	**3%**
Number of Stage 2 complaints where an extension was authorised	**5**
as % of the total number of Stage 2 complaints closed (13)	**38%**

3.7.5. Complaints Process Experience

The CHP requires the hospital to ask people their views about the procedure. A local feedback pro-forma was implemented with a view to seeking the feedback of those using the complaints process. Where appropriate PAS assist patients to complete this feedback. A total of 22 responses were received this year; compared to 25 in 2018/19 and 22 in 2017/18.

There was an improvement in respondents saying that all issues were answered (from 68% to 70%) and less respondents raised concerns about how their complaint had been handled (from 40% to 30%). However, there were decreases in the percentage of respondents who thought finding information about how to make a complaint was easy (from 85 to 70%); making a complaint was easy (from 96% to 70%); staff were helpful, polite and professional (from 92% to 80%); staff listened and understood my complaint (from 88% to 80%) and the letter advising me of the decision was easy to read and understand (from 76% to 70%).

3.7.6. Scottish Public Services Ombudsman (SPSO)
Complainants who remain unhappy with the response to their complaint from The State Hospital can ask the SPSO to review their complaint.

During 2019/20, two complaints were referred to the SPSO. Following a review of the complaints, the SPSO asked for an apology to be issued to one complainant and closed the file without further investigation. In regards the second complaint the SPSO were unable to obtain patient consent and could therefore not investigate the matter further.

3.8 Claims
During 2019/20 one new claim was received. No claims were settled during this period. Four claim files were closed for reasons other than settled: such as case abandoned, out of time etc. Eight claim files have been carried forward to 2020/21.

The table below shows the level of claims paid out over the last 5 years. There are regular reviews of cases with the Central Legal Office to ensure adequate financial planning.

	2015/16	**2016/17**	**2017/18**	**2018/19**	**2019/20**
Value of Claims Paid	£15k	£65k	£5.7k	£1k	**0**
Number of Claims Paid	2	2	2	1	**0**
Average Cost per Claim	£7.5k	£32k	£2.85k	£1k	**0**

As at end of March each year, the annual accounts include a provision for active claims where the Central Legal Office have advised on the likelihood of settlement and likely value. The assessed likelihood of settlement determines the approach taken to setting aside funds in the accounts.

The Board provides (funds set aside) for 100% of the value for high risk claims, and 50% for medium risk claims. A contingent liability is disclosed (no funds set aside) for 50% of the value of medium risk claims and 100% of low risk claims.

	2015/16	**2016/17**	**2017/18**	**2018/19**	**2019/20**
Provision Value	£176k	£111k	£21k	£67k	**£78k**
Provision No of Cases	7	4	4	4	**6**
Contingent Liabilities Value	£119k	£108k	£12k	£58k	**£83k**
Number of Cases	7	4	3	3	**7**

3.9 Training

3.9.1 Health & Safety Awareness Training
At 31 March 2020, overall compliance for Health & Safety Awareness training was 95% (an increase of 4.9% from 2018/19).

During 2019/20 a total of 77 staff attended Health & Safety Awareness training.

3.9.2 Manual Handling Training
At 31 March 2020, manual handling training had been completed by 99.8% of staff. Of this total, (an increase of 1.4% from 2018/2019)

In total, 95% of staff had completed Level 1 Manual Handling Awareness training, 98.3% *of* staff had completed the Manual Handling Essentials online training, with 92.7% of this group fully compliant with the bi-annual refresher requirements, and 90.1% had completed Level 2 Practical Training in Safer Manual/Patient Handling (an increase of 3.6% from the previous year).

During 2019/20 77 staff completed Level 1 awareness training (which is incorporated within the Health & Safety Awareness Training),178 staff completed the Manual Handling Essentials online training programme, and 127 staff completed Level 2 practical manual handling training.

3.9.3 Fire Safety Training
31 March 2020, a total of 99.5% of staff had completed fire safety awareness training (an increase of 1.6% from 2018/19).

A total of 528 staff completed the fire safety awareness training module during 2019/20. As of 31 March 2020, 80.6% of staff were fully compliant with annual refresher training requirements (a decrease of 6.2% from 2018/19), 18.9% were overdue annual refresher training and 0.5% had still to complete the online module.

3.9.4 Level 1 PMVA Training
Level 1 'Personal Safety & Breakaway' training is mandatory for non-clinical staff, with refresher training provided every 2 years. At 31 March 2020, a total of 94.6% of staff within the target group were compliant with Level 1 PMVA training requirements (a decrease of 1.3% from 2018/19) and 5.4% were overdue refresher training.

During 2019/20 a total of 166 staff plus 64 'external' delegates (e.g. students and volunteers) attended PMVA Level 1 (Breakaway) training.

3.9.5 Level 2 PMVA Training
Level 2 'Prevention & Management of Violence & Aggression' training is mandatory for all clinical staff employed under TSH terms & conditions, with refresher training provided every 2 years. At 31 March 2020, a total of 96.2% of staff within the target group were compliant with PMVA Level 2 training requirements (an increase of 4.3% from 2018/19) and 3.8% were overdue refresher training. During 2019/20 a total of 171 staff attended the Level 2 PMVA training.

3.9.6 Workshop on Raising Awareness of Prevent (WRAP) Training
At 31 March 2020, WRAP training had been completed by 68.2% (an increase of 7% from 2018/19). During 2019/20 a total of 76 staff attended WRAP training.

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

During 2019/20 the Risk Management Team received 3 FOI applications involving 12 questions. All were responded to within timescales.

4. Summary

4.1 Areas of Good Practice

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

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

Areas of good practice within the risk management department include:

- Continued development of the Corporate Risk Register with risk owners
- Progress made on resilience testing and plan updates.
- Pandemic Flu and Loss of Staff exercise undertaken in December 2019, plans updated thereafter, pre-covid.

4.2 Identified issues and potential solutions

Following our report of last year, we successfully recruited a Risk Management Facilitator in September 2019. Team resilience is currently a major issue with many functions being person dependant. Work is ongoing to improve departmental resilience.

SALUS Health and Safety sessions remain supporting the day to day management of health and safety arrangements and the workplace inspections/audits that also require to be undertaken.

4.3 Future areas of work and potential service developments

Recruitment is underway for part-time administrative support. This will help improve routine incident reporting and Datix administrative tasks. It is also hoped to assist with the reduction of Category 1/2 completion timescales.

Resilience priorities will be developed with the Security Director to ensure support for organisational resilience arrangements. This will include internal plan testing and training. Risk assessments have also been prepared in preparation for the withdrawal of the UK from the EU both locally via the Local Resilience Partnership and nationally via Scottish Government.

5. Next Review Date

The next annual report will be submitted to the Audit Committee in September 2021.

Appendix A: Corporate Risk Register

Ref No.	Category	Risk	Initial Risk Grading	Current Risk Grading	Target Risk Grading	Owner	Next Scheduled Review	Linked Corporate Objective	Governance Committee	RA ?	AP	Monitoring Frequency
Corporate CE 10	Reputation	Severe breakdown in appropriate corporate governance	Extreme x Possible	Extreme x Rare	Extreme x Rare	Chief Executive	31/05/20	Better Care	Board	Y/Y	N/A	Quarterly
Corporate CE 11	Health & Safety	Risk of patient injury occurring which is categorised as either extreme injury or death	Extreme x Possible	Extreme x Rare	Extreme x Rare	Chief Executive	31/05/20	Better Care	Clinical Governance	Y/Y	N/A	Quarterly
Corporate CE 12	Strategic	Failure to utilise appropriate systems to learn from prior events internally and externally	Major x Possible	Moderate x Possible	Moderate x Unlikely	Chief Executive	31/05/20	Better Care	Risk, Finance & Performance Group	Y/Y	N/A	Quarterly
Corporate CE 13	Strategic	Inadequate compliance with Chief Executive Letters and other statutory requirements	Moderate x Unlikely	Moderate x Rare	Moderate x Rare	Chief Executive	30/04/20	Better Care	SMT	Y/Y	N/A	6 monthly
Corporate MD 30	Medical	Failure to prevent/mitigate obesity	Major x Likely	Major x Likely	Moderate x Unlikely	Medical Director	31/03/20	Better Health	Clinical Governance Committee	Y/Y	Y/Y	Monthly
Corporate MD 32	Reputation	Absconsion of patients	Major x Unlikely	Major x Rare	Moderate x Rare	Medical Director	31/01/20	Better Care	SMT	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	31/01/20	Better Care	SMT	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	31/01/20	Better Care	SMT	Y/Y	N/A	Quarterly
Corporate MD 35	Medical	Non-compliance with Falsified Medicines Directive	Moderate x Unlikely	Moderate x Unlikely	Moderate x Rare	Medical Director	29/02/20	Better Health	Medicines Committee	Y/Y	N/A	Quarterly

Corporate SD 50	Service/ Business Disruption	Serious Security Incident	Moderate x Possible	Moderate x Possible	Moderate x Possible	Security Director	31/03/20	Better Care	SMT	Y/Y	N/A	Quarterly
Corporate SD 51	Service/ Business Disruption	Physical or electronic security failure	Extreme x Unlikely	Extreme x Unlikely	Extreme x Unlikely	Security Director	29/02/20	Better Care	Audit Committee	Y/Y	Y/Y	Monthly
Corporate SD 52	Service/ Business Disruption	Resilience arrangements that are not fit for purpose	Major x Unlikely	Major x Unlikely	Major x Rare	Security Director	30/04/20	Better Care	SMT	Y/Y	N/A	Quarterly
Corporate SD 53	Service/ Business Disruption	Serious security breaches (eg escape, intruder, serious contraband)	Extreme x Unlikely	Extreme x Unlikely	Extreme x Unlikely	Security Director	29/02/20	Better Care	Audit Committee	Y/Y	Y/Y	Monthly
Corporate SD 54	Service/ Business Disruption	Climate change impact on The State Hospital	Minor x Possible	Moderate x Possible	Minor x Possible	Security Director	30/04/20	Better Care	SMT/Resilience Committee	Y/Y	N/A	Quarterly
Corporate SD 55	Service/ Business Disruption	Negative impact of EU exit on the safe delivery of patient care within The State Hospital	Moderate x Unlikely	Moderate x Unlikely	Moderate x Rare	Chief Executive	29/02/20	Better Care	SMT	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	29/02/20	Better Care	SMT	Y/Y	Y/Y	Monthly
Corporate ND 71	Health & Safety	Failure to assess and manage the risk of aggression and violence effectively	Major x Possible	Major x Possible	Major x Possible	Director of Nursing & AHP	29/02/20	Better Care	SMT	Y/Y	Y/Y	Monthly
Corporate ND 72	Service/ Business Disruption	Failure to evolve the clinical model, implement and evidence the application of best practice in patient care	Moderate x Possible	Moderate x Possible	Moderate x Unlikely	Director of Nursing & AHP	29/02/20	Better Care	SMT	Y/Y	N/A	Quarterly
Corporate ND 73	Service/ Business Disruption	Lack of SRK trained staff	Moderate x Likely	Moderate x Possible	Moderate x Unlikely	Director of Nursing & AHP	30/04/20	Better Care	PMVA group & SMT	Y/Y	N/A	Quarterly

Corporate FD 90	Financial	Failure to implement a sustainable long term model	Moderate x Unlikely	Moderate x Unlikely	Moderate x Rare	Finance and Performance Director	31/01/20	Better Value	Audit Committee & SMT	Y/Y	N/A	Quarterly
Corporate FD 91	Service/ Business Disruption	IT system failure/breach	Moderate x Possible	Moderate x Possible	Minor x Possible	Finance and Performance Director	31/01/20	Better Value	Information Governance Group & SMT	Y/Y	N/A	Quarterly
Corporate FD 93	Health & Safety	Failure to complete actions from Cat 1/2 reviews within appropriate timescale	Moderate x Possible	Moderate x Possible	Moderate x Unlikely	Finance and Performance Director	31/01/20	Better Care	CEBM, SMT	Y/Y	N/A	Quarterly
Corporate FD 94	Service/ Business Disruption	Inadequate data centre	Moderate x Likely	Moderate x Possible	Moderate x Unlikely	Finance and Performance Director	29/02/20	Better Care	SMT/Resilience Committee	Y/Y	N/A	Quarterly
Corporate FD 95	Service/ Business Disruption	Lack of IT on-call arrangements	Moderate x Possible	Moderate x Unlikely	Moderate x Unlikely	Finance and Performance Director	31/03/20	Better Care	SMT/Resilience Committee	N/A	N/A	Quarterly
Corporate FD 96	Service/ Business Disruption	Cyber Security/Data Protection Breach due to computer infection	Moderate x Unlikely	Moderate x Unlikely	Moderate x Unlikely	Finance and Performance Director	31/03/20	Better Care	SMT/Resilience Committee	Y/Y	N/A	Quarterly
Corporate FD 97	Reputation	Unmanaged smart telephones' access to The State Hospital information and systems.	Major x Likely	Major x Possible	Major x Unlikely	Finance and Performance Director	29/02/20	Better Value	Information Governance Group & SMT	Y/Y	Y/Y	Monthly
Corporate HRD 110	Resource	Failure to implement and continue to develop the workforce plan	Moderate x Possible	Moderate x Possible	Minor x Rare	Interim HR Director	30/11/19	Better Workforce	SMT	Y/Y	N/A	Quarterly
Corporate HRD 111	Reputation	Deliberate leaks of information	Major x Possible	Major x Likely	Moderate x Unlikely	Interim HR Director	01/12/19	Better Care	SMT	Y/Y	Y/N	Monthly
Corporate HRD112	Health & Safety	Compliance with Mandatory PMVA Level 2 Training	Major x Unlikely	Major x Unlikely	Major x Rare	Interim HR Director	30/11/19	Better Care	H&S Committee	Y/Y	N/A	Quarterly

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 October 2020
Agenda Reference:	Item No: 19
Sponsoring Director:	Chief Executive
Author(s):	Head of Communications Person Centred Improvement Lead
Title of Report:	Communications Annual Report 2019/20
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 2019 to 31 March 2020.

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). The Intranet is managed by eHealth.

3 ASSESSMENT

Overall, core Communications tasks including key performance indicators, quality assurance objectives and quality improvement objectives were delivered. All legislative requirements were met, and all financial targets / savings were achieved.

A breakdown of the 76 (78 in 2018/19) key areas of activity is shown below:

- There were 26 (26 in 2018/19 and 22 in 2017/18) tasks relating to core objectives. Of these 13 were Key Performance Indicators (KPIs) and 13 were outputs in respect media, public, patient, carer, volunteer, external, and staff activity.

- Additionally, 50 (52 in 2018/19 and 36 in 2017/18) objectives focused on quality; 19 related to quality assurance and 31 to quality improvement. The latter evidencing our commitment to continuous improvement.

There is no doubt that the ongoing functioning and future proofing of the Communications Service would benefit from adequate investment to complement the current single person resource. This would address the growing backlog and enable the Service to explore more modern methods of communication to add variety and ensure existing methods do not become dated. More importantly, the challenges and risks associated with a sole post are well documented. This much needed investment to sufficiently resource this important Service would not only enable the best and most effective use of the current resource, but would build capacity for the future with an emphasis on appropriate resilience, succession planning and growth.

Whilst media enquiries reduced (from 40 in 2018/19 to 19 in 2019/20), it is recognised that this area of activity would also benefit from investment in 2020/21.

4 RECOMMENDATION

The Board is asked to note the Communications Annual Report 2019/20.

Author:
Caroline McCarron
Head of Communications
01555 842016

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	All communications activity supports the Hospital to meet its strategic objectives as outlined in the Hospital's Annual Operating Plan / LDP Objectives.
Workforce Implications	Assessed with the report in respect of workforce.
Financial Implications	There are no specific financial impacts identified.
Route to Board Which groups were involved in contributing to the paper and recommendations.	Board requested through workplan to lend oversight.
Risk Assessment (Outline any significant risks and associated mitigation)	Risk to organisational reputation.
Assessment of Impact on Stakeholder Experience	Stakeholder experiences identified and described within reporting.
Equality Impact Assessment	Not required.
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	No specific impacts identified.
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One ☑ There are no privacy implications. ☐ There are privacy implications, but full DPIA not needed ☐ There are privacy implications, full DPIA included.

COMMUNICATIONS ANNUAL REPORT 2019/20

THE STATE HOSPITALS BOARD FOR SCOTLAND

1. CORE PURPOSE

Effective communications plays 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 and the production of corporate publications. In particular, the 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 therefore our 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.

Key results areas include:

- Stakeholder Communications (internal and external).
- Public Relations.
- Media Relations.
- Crisis Communication.

2. LOCAL AND NATIONAL DRIVERS

Communications is delivered in line with our Corporate Communications Strategy which meets the legal obligations contained within:

- The State Hospital Annual Operating Plan 2019/20.
- Person Centred Improvement Service Delivery Plan 2018/21.
- National Staff Governance Standard (4th edition), June 2012.
- NHSScotland Healthcare Quality Strategy, May 2010.
- NHSScotland 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 – which is available on The State Hospital's Website under Board Business - focuses on internal and external corporate 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. The strategy is nearing its shelf life and is in the process of being updated.

The Media Policy & Procedure, Website Maintenance & Development Policy and other relevant documentation support the Corporate Communications Strategy including the discrete Pandemic Influenza Communications Strategy 2020/25.

3. STAFFING / RESOURCES

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 our audiences.

The Communications function comprises just one post – Head of Communications.

The resources allocated to the Communications function have not kept pace with the expanding role / gradual increase in responsibilities over the years. This now means that the amount of time that can be dedicated to each area of activity is inadequate, impacting on the Hospital's ability to deliver its agenda. As a result, attention is primarily on meeting operational demands, associated admin tasks and work backlog, leaving little time for appropriate strategic thinking or service development.

The State Hospital has expressed a clear desire to communicate more effectively and now needs to address resource issues necessary to tackle the evolving agenda and mitigate risks associated with burnout, resilience and building capacity, succession planning, and the best use of skills and resources.

4. 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	By August each year	**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 2020	**Complete** A total of 50 were produced.
04	To produce at least 40 special bulletins as a support to staff.	CEO	-	**Complete** A total of 74 were produced. Of these, 20 related to Covid-19.
05	To produce Staff Newsletter 'Vision' twice a year as a minimum.	CEO	By end March 2020	**Complete** Eight issues were produced.
06	To deliver on 100% of all appropriate requests for Talks to the Community.	General Public	By end March 2020	**Complete** Two general State Hospital presentations were delivered.
07	To respond to 100% of urgent Media Enquiries within the timescale requested and within one working day.	Media	By end March 2020	**Complete** There were 19 media enquiries.
08	Meet the requirements of the 'Well Informed' Staff Governance Standard.	Staff Governance Standard	March / April 2020	**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** Criteria 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 with a view to identifying information / communication for the staff bulletin, staff newsletter 'Vision', Intranet, Website and the Media as appropriate.

No	KPI	Source	Timescale	Status / Outcome
11	To attend 90% of NHSScotland Strategic Communications Network Meetings.	NHSScotland	By end March 2020	**Complete** Criteria met.
12	To ensure representation at the annual NHSScotland Event.	NHSScotland	Annually in June	**Continues to be met** Achieved through individual representation including submission of poster abstracts. The Board agreed that no 'stand' would be taken from 2018 onwards.
13	Annual re-design of Weekly Staff Bulletin and Special Bulletin.	Chairperson	By end March annually	**Continues to be met**

The table below details activity not covered by KPIs:

No	Workstream	Lead	Outcome	Key Result Area
01	Media Releases	Head of Comms	There were no Media Releases issued as there was no requirement.	Media Relations
02	Media Features	Head of Comms	Eight articles were published. Three of these in international newsletters.	Media Relations
03	Media Leaks	Head of Comms	Three were reported through Datix.	Media Relations
04	FOI Enquiries	FOI Lead	A total of 224 enquiries were responded to. Of these, there were four separate FOI Media requests that asked six questions in total. Note! There will be a change to the method of recording FOI requests from 2019/20 onwards. Every distinct question will now be recorded as a request rather than each applicant's request.	Public Relations
05	Academic Published Articles	Research & Development Manager	The Research Committee and Research Funding Committee Annual Report 2019/20 notes 15 published journal articles and the delivery of 31 presentations.	Public Relations
06	Continue to invite visitors to the Hospital to learn about our 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

No	Workstream	Lead	Outcome	Key Result Area
07	Patient Newsletters	Person Centred Improvement Advisor (PCIA)	A weekly patient bulletin is produced which is displayed on all patient noticeboards within the Hospital.	Patient Relations
08	Carer Updates	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 update newsletter is produced as required, in addition to the Staff Bulletin and other relevant information being shared with volunteers who have consented to receive same.	Volunteer Relations
11	Networking: Presentations / Workshops	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 & Volunteer Visitor Programme, Augmentative Communication, using creative feedback methods to engage with complainants and Person Centred Quality Improvement initiatives including person centred visiting Equality agenda including practice relating to 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	Six took place. All in clinical areas.	Staff Relations and Patient Engagement

5. QUALITY ASSURANCE (QA) OBJECTIVES

The table below shows all QA Objectives for 2019/20 and progress against same:

No	QA Objective	Source	Lead	Timescale	Status / New Timescale
	Internal Communications				
01	Review all patient publications in line with 'Accessible Information' standards.	Patient Feedback	PCIL and Head of Comms	March 2020	**Complete** 31 publications reviewed.
02	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**
03	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	March 2020	**Action no longer required** Our intention now is to move SharePoint to Cloud via Office 365. This has yet to be planned but will mitigate the risk we have with our 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).
04	Review and update publications (as appropriate) in the Hospital's Publications Database.	Comms	Head of Comms	Ongoing	**Completed 2019/20** A review of all information sheets for Dietetics, the Health Centre, Infection Control, Physical Health Steering Group, Psychological Therapies Service, and Social Work.
05	Review of the Staff Charter.	Comms Audit	Interim Director of HR	March 2020	**Complete** It was agreed that the Staff Charter was no longer required. Measurement is via the Staff Governance Standard.

No	QA Objective	Source	Lead	Timescale	Status / New Timescale
External Communications					
06	Annual review and update of all Person Centred Improvement Service publications.	PCISG	PCIL	Annually	**Continues to be met**
07	Undertake an annual review and update of the content on the Website.	Comms	Head of Comms	By August each year	**Continues to be met**
08	Annual review and update of all Person Centred Improvement Service text on The State Hospital Website.	PCISG	PCIL	Annually	**Continues to be met**
09	Production of Employment Monitoring Reports for the Website.	Equality Act	Interim Human Resources Director	Every two years – June 2021	**Ongoing** Report for 2018/19 published on the webstie on 6 June 2019.
10	Produce an annual report on Website statistics for 2019/20.	Comms	Head of Comms	March 2020	**Complete** Website Traffic Report 2019/20 was produced for presentation to 1 September 2020 meeting of the FOI Committee.
11	Explore Web Archiving with National Records Scotland (NRS).	Records Management Plan	Health Records	December 2019	**Complete** We now have pages available via the National Records for Scotland (NRS) website.
12	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** Text from the Board's Annual Report is used to populate the various screens.
13	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 is done based on feedback from presentations.
14	Ensure Contingency Planning Comms contacts (Police, Fire and Ambulance) are updated.	Security Director	Head of Comms	Annually	**Continues to be met**

No	QA Objective	Source	Lead	Timescale	Status / New Timescale
			External Communications		
15	Review of Contingency Planning Comms Statements.	Comms	Chief Executive / Head of Comms	March 2020	**Complete**
16	Bi-annual review of Media Training requirements for Directors and other identified staff.	Comms	Chief Executive / Head of Comms	March 2020	**Complete** No requirement in 2019/20.
17	Familiarisation with **'**Dealing With The Media' Guidance for State Hospital Spokespeople	Head of Comms	On-Call Directors / CEO	December 2019	**New for 2019/20** **Complete** 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.
			Strategy / Policy		
18	Carry out an interim review and update (if required) of Communications strategies, policies and procedures.	Comms	Head of Comms	Annually	**Continues to be met**
19	Undertake Equality Impact Assessments for Communications.	Equality Act	Head of Comms	March 2020	**Complete**

6. QUALITY IMPROVEMENT (QI) OBJECTIVES

The following table details QI Objectives for 2019/20 including progress against same:

No	QI Objective	Source	Lead	Timescale	Status / New Timescale
		Internal Communications			
01	Develop a Supporting Patient and Carer Communication Policy.	Patient / Carer Feedback and Scottish Health Council (SHC)	PCIL	November 2019	**Complete**
02	Ensure adequate Person Centred Improvement Service (PCIS) resourcing to support continunity of the ward outreach programme to ensure the views of 'hard to reach' patients are elicited.	Equality Act	PCIL	February 2020	**Complete**
03	Continue to undertake Staff Engagement Exercises to support corporate objectives.	Directors Objectives	Head of Comms	Ongoing	**Continues to be met** e.g. Review of Clinical Model in 2019/20
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 2020	**Complete**
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	Support / promote iMatter	Board	OD Manager / OD & Learning Advisor / Head of Comms	Ongoing	**Continues to be met**

No	QI Objective	Source	Lead	Timescale	Status / New Timescale
Internal Communications					
08	Produce promotional materials for TSH3030	Clinical Governance Committee	Dr Gordon Skilling / HCPBS / Risk Management Team Leader / Head of Comms	By end Oct 2019	**Complete** In addition to emails and staff bulletin articles, a range of promotional materials were produced in 2019/20 including mugs, travel mugs, post its, pens and scribble pads.
09	Promote the work of Infection Control	Infection Control Committee	Senior Nurse for Infection Control / Head of Comms	Ongoing	**Continues to be met** In addition to emails and staff bulletin articles, a range of promotional materials were reproduced in 2019/20 including post its, pens and pencils.
10	Promote the launch of Staff and Volunteer 'Excellence Awards' through a communications campaign.	Values & Behaviours Group	OD Manager / OD & Learning Advisor / Head of Comms	By May 2019	**New for 2019/20** **Complete** In addition to emails and staff bulletin articles, a range of materials were produced including logo, posters, certificates, banner stand, nomination boxes and staff information. A special edition of Vision was produced in November 2019 highlighting the winners following the Excellence Awards Ceremony on 25 December 2019. **New for 2020/21** Production of Excellence Awards banner.
11	Enable patients to contribute to the voting process of the Staff and Volunteer 'Excellence Awards' through the use of tailored communications materials.	Excellence Steerting Group	PCIL	By May 2019	**Complete**

No	QI Objective	Source	Lead	Timescale	Status / New Timescale
			Internal Communications		
12	Deliver a communications campaign to promote the launch of staff Long Service Awards.	Values & Behaviours Group	OD Manager / OD & Learning Advisor / Head of Comms	By May 2019	**Complete** This involved the promotion of the awards as well as the production of certificates and badges for 20, 30 and 40 years' service.
13	Promote manual handling through a communications campaign.	Manual Handling Advisor	Manual Handling Advisor / Head of Comms	End August 2019	**Complete** A Display Screen Equipment (DSE) banner stand and patient information 'Manual Handling – Taking Care of Your Back' was produced.
14	Directors to explore and implement opportunities for becoming more visible across the site.	iMatter	CEO / Directors	March 2020	**Complete** An example of progress was our pilot of better interface working and Director visibilitity, e.g. in terms of the outcome of the Clinical Model work, Directors delivered site-wide presentations and facilitated Q&A sessions. The pilot was a success and this form of communication will continue going forward.
			External Communications		
15	Explore measures with external Consultant to raise the Hospital's profile and address negative media reporting.	CEO / Board	Chief Executive / External Consultant / Head of Comms	March 2020	**In progress** Consultant has been commissioned. Work will continue into 2020/21.
16	Produce a PCIS banner for the Patient Visitor Reception Area.	PCIS	PCIL / Head of Comms	End June 2019	**Complete**
17	Redesign and relaunch of State Hospital Website.	Board	Head of Comms	March 2021	**On target** Website will be redesigned by NHS 24. First meeting took place in March 2020 but then paused due to Covid-19.

No	QI Objective	Source	Lead	Timescale	Status / New Timescale
			External Communications		
18	Ensure research is shared through the Website.	Board	Research & Dev Mgr / Medical Director	March 2021	**On target**
19	Create a new section on the State Hospital Website for Freedom of Information (FOI) Disclosure Logs and populate.	FOI legislation	Information Governance and Data Security Officer / Head of Comms	By April 2019	**Complete** Ongoing – population.
20	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** **On target**
			Collaborative Working		
21	Facilitate' What Matters To You?' initiative seeking the views of patients, carers and volunteers.	HIS	PCIL	Annual	**Continues to be met** Every June.
22	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 submitted four articles for the National Collaborative newsletter in 2019/20. An article was also produced for National Board staff newsletters. From December 2019, The State Hospital hosted a web page for use by the National Collaborative.
23	Explore a 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	Ongoing	**Nearing Completion** Draft MoU produced by the Head of Communications and approved by CEO. Just waiting on final sign-off from NHS Golden Jubilee .
24	With NHSScotland 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		
25	Develop the leadership needs of NHSScotland Communications professionals: Directors of Communications and Heads of Service.	Strategic Comms Group	Strategic Comms Leadership Sub Group	Ongoing	**On target** Sub Group comprises The State Hospital, NHS Greater & Clyde, and NHS Golden Jubilee. An audit of needs has been undertaken. Options will now be explored to meet these particular needs.
			Equality, Diversity and Rights		
26	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.
27	Develop dedicated proformas with carers to support the sharing of feedback specifically in relation to the admission, continuing care, pre transfer and post transfer stages of the carer journey.	CSG / Carers Trust Scotland	PCIL / PCIA	September 2019	**Complete**
28	Consult, publish and implement updated 2017/20 Equality Outcomes.	PCISG	PCIL	April 2021	**On target**
			Strategy / Policy		
29	Develop a Supporting Patient and Carer Communication Policy.	Patient / Carer Feedback and Scottish Health Council (SHC)	PCIL	November 2019	**Complete**
30	Update local Interpretation and Translation Policy.	Equality Act	PCIL / Associate Medical Director	December 2019	**Complete**
31	Review Communications Resilience Risk Assessment (departmental risk register).	Risk Management	Head of Comms	As required	**Continues to be met**

7. OUTCOMES AND EFFECTIVENESS

The following are examples of positive outcomes evidencing effectiveness in 2019/20:

7.1 Patient / Carer / Volunteer Focus

- The 2019 'What Matters to You?' initiative was well supported throughout the Hospital with lego used for the first time to support constructive thinking enabling hard to reach patients e.g. those with autism, intellectual disability and dementia to engage.

- In February 2020, patients, carers and volunteers engaged with staff to undertake the Equality Impact Assessment in relation to the revised Clinical Service Delivery Model.

- A total of 64 patients engaged in the Hospital wide TSH3030 quality improvement initiative.

- The Carers Support Group helped develop the draft 'What Matters to You?' Carers Plan.

- The Patient Partnership Group responded to 11 policy consultations during the course of the year, which were publicised through the Staff Bulletin and shared by the PCIS.

- The Patient Chair of the Patient Partnership Group was supported to present the Volunteer Excellence Award as part of the Staff Excellence Award Ceremony.

- In terms of networking, presentations and workshops were delivered throughout the year 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 & Volunteer Visitor Programme, Augmentative Communication, using creative feedback methods to engage with complainants and Person Centred Quality Improvement initiatives including person centred visiting and the Equality agenda including practice relating to Protected Characteristic Groups Equality Outcomes and Equality Impact Assessments.

- To ensure the Board has the opportunity to learn from the experience of patients, carers and volunteers, emotional touchpoint presentations regularly feature on the Board's agenda.

- Non Executive Board Members attend Patient Partnership Group meetings on a rotational basis to hear directly from patients about their experience of care and treatment.

7.2 Internal Communications

- In 2019 we completed the fifth cycle of iMatter. The 2019 National Health and Social Care Staff Experience Report was positive, in particular when comparing our performance against that of other Boards. There are five strands to the Staff Governance Standard – the 'Well Informed' strand scored the top mark with 82% of staff saying they felt well informed; the other four strands scored between 73-79%. In terms of the Staff Governance Standard, our performance overall is the best it has been for the past five years. We can take heart and keep up our good efforts for the future.

- High response rates to staff engagement exercises (issued by Email, housed on the Intranet and advertised through the Staff Bulletin) show that our electronic communications are well utilised by staff. For example, Sturrock Report (July 2019) and the Clinical Model Review (September 2019).

- Internal and external events were promoted through the Staff Bulletin, Intranet and Email with high attendance achieved for the weekly Journal Club, annual State Hospital Clinical Effectiveness & Research Conference, annual NHSScotland Event, health promotion events, learning opportunities, and general conferences and events.

- During the year 'Vision' continued to be enjoyed by staff. In addition to numerous verbal positive comments throughout the year, the following is an example of written feedback received in August 2019:

    - "I enjoyed this edition….interesting variety of topics. I like the getting to know you sections and the various staff photos which allow me to put names to faces with other disciplines."

- Although Vision and the Staff Bulletin both provide a mixture of formal local and national news, Vision includes human interest stories and brings to life events through the use of photos, e.g. in 2019/20 coverage included seven Getting to Know You staff articles, eight staff farewell articles, and promotion / feedback relating to Carers Week, Volunteers Week, patient and staff MacMillan Coffee Mornings, Moderator Visit, Global Citizenship, National Collaborative, Broadmoor, and Talks to the Community. Contributions were received from the 'shop floor' to middle managers, Directors and the Chief Executive.

- Through Email, the Intranet and the Staff Bulletin, staff were able to provide responses to policy consultations throughout the year prior to approval and implementation.

- The Intranet continued to be an effective electronic communications tool for housing and sharing information including latest news.

- Email continued to be used for urgent communications or those that are not included in the Staff Bulletin, e.g. weather warnings, grounds access time changes, and items sought or no longer required (with numerous items being exchanged), works on site, programme downtimes, public holiday staffing, lost property etc.

- During February 2020, Communications supported the writing of four poster abstracts for submission in respect of the NHS Scotland Event scheduled for June 2020. This ensured submissions were the best they could be in meeting the specific scoring criteria.

- Communications support was given to various disciplines throughout the year. For example, promotion included TSH3030, AHP 400-yard campaign, Security Christmas Jumper Day, Harris Secret Santa, Daily Mile, Excellence Awards, Long Service Awards, Infection Control, Backcare Awareness, Unison profiles, Suicide Prevention, Go with Flo, Weigh to Go, Student Nurses, Mental Health Nurses Day etc.

- Promotional materials were produced for TSH3030, Keeping the Bugs at Bay (Infection Control) and Values & Behaviours, and were well received by staff, e.g. mugs, water bottles, pens, pencils, notepads, post-it pads, mouse mats and spectacle cloths.

- Requests for printed materials continued, evidencing fit for purpose and in demand.

7.3 External Communications

- Our State Hospital general presentation to local community groups continued to be received well. This is evidenced through our feedback forms which are extremely positive. A snapshot of feedback from talks to community in 2019/20 follows:

    - "Thank goodness there's places like The State Hospital. I have lived in Lanark for over 50 years and never knew anything about what goes on at The State Hospital. It was so interesting and informative. Keep up the good work".
    - "Excellent work done by dedicated people".
    - "Most informative and interesting talk with a mixture of slides (pictures), information and facts about the hospital and personal enthusiastic input from the presenter".
    - "Very interesting, a real insight into Carstairs, how it works and the sort of life the patients have".
    - "It was very interesting, not something I ever knew or thought about".
    - "The presenter came across as compassionate and caring in telling us about mental health issues".
    - "Excellent speaker, very clear and patient in answering many questions".

    Our presence in the local community continues to lead to requests for further talks and helps to reduce stigma around mental health.

- Hosting visits to the Hospital ensures a wider audience learns about our work and enables the opportunity of sharing best practice and networking. Details of these visits are included in the Chief Executive's Report to each Board meeting.

- At each Board Meeting, the Chairperson provides feedback from the NHSScotland Chairs' Meeting. This ensures the Board is aware of what is happening nationally and includes updates on targets and priorities. This information is then shared with staff via the dedicated Board Bulletin.

- Through the effective management of media enquiries, we were able to protect the Hospital's reputation by either (1) quashing what could have been a potential news story or (2) by lessening the impact of a negative story through rebutting inaccuracies and providing information to ensure fair and balanced coverage. Details of media enquiries / contacts are shared with Scottish Government colleagues and we often work together to ensure a joined up response by sharing lines etc.

- Every day we receive enquiries and Freedom of Information (FOI) requests through the general State Hospital email box (tsh.info@nhs.net) evidencing that this is not only effective but a popular resource.

- In 2019/20, our website received 13,831 visits / 31,578 page views, providing assurance that our key electronic communications tool for the general public continues to be well utilised.

8. SUMMARY / CONCLUSION

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). The Intranet is managed by eHealth.

Overall, core Communications tasks including key performance indicators, quality assurance objectives and quality improvement objectives were delivered. All legislative requirements were met, and all financial targets / savings were achieved.

There is no doubt that the ongoing functioning and future proofing of the Communications Service would benefit from adequate investment to complement the current single person resource. This would address the growing backlog and enable the Service to explore more modern methods of communication to add variety and ensure existing methods do not become dated. More importantly, the challenges and risks associated with a sole post are well documented. This much needed investment to sufficiently resource this important Service would not only enable the best and most effective use of the current resource, but would build capacity for the future with an emphasis on appropriate resilience, succession planning and growth.

Caroline McCarron
Head of Communications
25 September 2020

Board Paper 20/74

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 October 2020
Agenda Reference:	Item No: 20
Sponsoring Director:	Chief Executive
Author(s):	Board Secretary
Title of Report:	Annual Review 2019/20 – Update
Purpose of Report:	For Noting

1 SITUATION

Scottish Government has issued guidance to all Health Boards in relation to this year's Annual Review of NHS Scotland. Scottish Government has advised that The State Hospital Board for Scotland will have a Ministerial Review and that this will take place on 10 November 2020.

2 BACKGROUND

Scottish Government has advised that that the Ministerial Review at The State Hospital will take place by way of video-conference, due to Covid-19 restrictions.

The review will be chaired by Ms Clare Haughey, Minister for Mental Health, supported by Ms Donna Bell, Director of Mental Health. The Board will be represented by the Chair and Chief Executive supported by the Board Secretary. A letter will follow from the Minister to outline the outcome of the review, and this will be published on the Board's website.

3 ASSESSMENT

The core purpose of the Annual Review will continue to be for NHS Boards to be held to account for their performance.

The format of the review will encompass a review of performance for the period 1 April 2019 to 31 March 2020, as well as the activity and experience of the Board during the Covid-19 pandemic. The Minister will also wish to review remobilisation planning for The State Hospital.

As the Minister is not able to meet with staff in the usual way, due to Covid-19 restrictions, the Clinical Forum and the Partnership Forum have been invited to provide any comments and/or suggested questions to be included in the review.

An update will be provided to the Board at its next meeting on 17 December 2020.

4 RECOMMENDATION

The Board is invited to **note** Scottish Government guidance for this year's Ministerial Review, and that further updates will be provided to the Board.

Author:
Margaret Smith
Board Secretary
01555 842012

Board Paper 20/74
MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	To inform the NHS Board on Scottish Government arrangement for its Annual Review of the Board.
Workforce Implications	Noted that the Partnership Forum have been asked to contribute, in context of Covid-19 restrictions.
Financial Implications	None directly considered.
Route To Board Which groups were involved in contributing to the paper and recommendations.	Board requested as part of its workplan
Risk Assessment (Outline any significant risks and associated mitigation)	No direct consequences and the report is for information
Assessment of Impact on Stakeholder Experience	Noted in report indicating Clinical Forum and Partnership Forum involvement.
Equality Impact Assessment	Not required.
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	Not applicable.
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One X There are no privacy implications. □ There are privacy implications, but full DPIA not needed □ There are privacy implications , full DPIA included.

Board Paper 20/75

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 October 2020
Agenda Reference:	Item No: 21
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 Corporate Governance Blueprint.

The Board submitted its improvement plan to Scottish Government in April 2019, and submitted a six-month progress report in November 2019.

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

3 ASSESSMENT

At the outset of the Covid-19 pandemic, this workstream was necessarily paused as part of The State Hospital's resilience response. The improvement plan was last reviewed by the Board at its meeting on 27 February 2020.

The State Hospital's Remobilisation Plan for the period to 31 March 2021 includes a restart of this workstream.

Further, and as part of re-mobilisation across NHS Scotland, work is underway through the NHS Chairs Group to build on its previous work on the Blueprint for Good governance and a 'Once for Scotland' governance model that will deliver a consistent, coherent and cohesive approach. This is being led through the Corporate Governance Steering Group and Corporate Governance Programme Board.

A key initiative is through leadership on 'Active Governance' across NHS Scotland which is comprised of two substantive and linked components:

- Assurance information system to ensure NHS Boards have the necessary information system to give assurance on performance delivery including strategic, operational and financial plans, benchmarking performance against similar organisations.
- Design and develop a development programme for Board Members to ensure they can engage with assurance information to inform decision-making and identify substantive issues that could detrimentally affect the organisation's culture, performance and reputation.

A Board Seminar has been arranged for 4 November focussed on the development of the Blueprint for Good Governance for The State Hospital. This will support linkage to the 'Once for Scotland' approach nationally and the key aspects of this refreshed approach through 'Active Governance'.

A further update will be brought to the next meeting of the Board on 17 December 2020.

4 RECOMMENDATION

The Board is asked to **note** the:

- restart of this workstream as part of the Remobilisation Plan.
- Improvement Plan updated in February 2020, and paused since that date.
- Board Seminar scheduled for 4 November 2020.

Author:
Margaret Smith
Board Secretary
01555 842012

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	In support of the Corporate Governance Blueprint, and development of a Once for Scotland approach for cohesive governance across NHS Scotland
Workforce Implications	None identified to date
Financial Implications	None identified to date
Route To Board Which groups were involved in contributing to the paper and recommendations.	Board requested as part of workplan – to enable reporting to Scottish Government
Risk Assessment (Outline any significant risks and associated mitigation)	None identified to date
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. □ 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 utilization and safe staffing legislation.	Director of Nursing and AHPs	CMT	March 2020	**On Track**. Work is ongoing to ensure effective rostering is in place with the support of electronic systems. Currently testing SSTS eRostering module in one ward with a view to rolling this out wider. Restrictions on effective rostering remain due to fixed shift pattern; alternative, flexible shift pattern introduced for all new appointments to ward nursing posts. This has increased capacity and much more flexibility to support effective rostering. Internal Audit are undertaking work in January to review preparedness for safe staffing legislation. **Update:** RSM undertook audit 6th to 10th January 2020, results of which were presented to the January meeting of the Audit Committee. A range of actions linked to this

						point have been accepted and are being progressed.
	3	Development of more robust processes to compare planned and actual spend and to account for any variance.	Director of Finance & PM	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	**On Track**
	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	October 2019	**On Track.** Training for Line Managers and HR Managers implemented. Update presented on attendance management to each Board Meeting. AMITG paused to reflect action plan implemented and wider work plan.
	6	Implementation and compliance with Once for Scotland HR policies within TSH. Focus on policy awareness through completion of	Interim HR Director	Partnership Forum/CMT	December 2019	**On Track** – to align with roll out of the national guidance.

		metacompliance / staff bulletins/ staff training in Single Investigatory process.				
	7	Review performance framework and assurance information systems to support review of performance.	CEO	CMT	July 2019	**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.
	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 of Finance	Audit Committee / Board	December 2019	**On Track:** Underway through closer Risk Register monitoring and review process (managed by Risk Team Leader) and reporting to Risk Finance and Performance Group – All risk register items either now with action plan in place or underway. Board Workplan 2020 includes regular updates on Corporate Risk Register.

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	March 2020	**Review of media strategy in progress:** with regular updates to the 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	March 2020	**Ongoing** – engagement work commenced at university level to recruit new graduates to nursing posts. This was trialed in one University and plan is to roll out further for 2020 graduates. Further recruitment to take place early 2020 for registered nurses.
	12	Encourage carers / volunteers /staff / local population to attend public Board Meetings through additional promotion and links with local community.	Board Secretary	Board	September 2019	**On Track** – through promotion of external Board Meetings /Annual Review session in 2020.
	13	Hold two Board Meeting each year at external locations to promote role as national Board.	Board Secretary	Board	April 2020	**On Track** - Board Meeting 27 February in Lanark Memorial Hall, and can be evaluated to inform future planning.
	14	Annual Review - Public Meeting to be held outside of the hospital to help engage public engagement and attendance.	Board Secretary	Board	April 2020	Plan to be progressed as part of Annual Review planned expected summer 2020.
INFLUENCING CULTURE	15	Define culture in The State Hospital in terms of key strengths and	CEO	Board	December 2019	**Review in progress** – progressed in conjunction with response to Sturrock and Clinical Model

		weaknesses - take forward through development sessions				Review – Culture, Values & Behaviours, Leadership workstream led by CEO.
	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	March 2020	**On Track** - QI Forum initiatives underway. TSH 3030 took place successfully in November 2019, with update to Board in December.
	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	July 2019	**On Track** - wider engagement across TSH – progressed in conjunction with response to Sturrock and Clinical Model Review.
	19	Senior Team / RMO presence at key events in hospital calendar e.g. patient learning awards/ sportsman dinner. Promote this through management structures.	CEO / Medical Director	CMT	September 2019	**On Track** -Coordination of central diary of events to help facilitate attendance.
	20	Link in with Scottish Government once appointment of the Independent National Whistleblowing Champion has been appointed.	CEO	Board	April 2020	**On Track** - appointment confirmed as Scottish Public Service Ombudsman at national level, and local appointment made to Board. National training event scheduled on 28 February.
	21	Plan a schedule of Non-Executive Director informal visits across TSH to help promote the values and behaviours of the organisation.	Chair	Board	August 2019	**On Track** - Schedule in place for patient and staff engagement

THE STATE HOSPITALS BOARD FOR SCOTLAND

DRAFT Minutes of the meeting of the Audit Committee held on Thursday 18 June 2020 at 9.45am via Microsoft Teams

PRESENT:

Non-Executive Director	Bill Brackenridge
Employee Director	Tom Hair
Non-Executive Director	David McConnell ***(Chair)***
Non Executive Director	Brian Moore

IN ATTENDANCE:

Internal

Board Chair	Terry Currie
PA to Finance and Performance Management Director	Fiona Higgins ***(Minutes)***
Chief Executive	Gary Jenkins
PA to Chair and Chief Executive	David McCafferty
Finance and Performance Management Director	Robin McNaught
Head of Corporate Planning and Business Support	Monica Merson
Board Secretary	Margaret Smith

External

Internal Auditor, RSMUK	Sue Brooke
Partner, Scott Moncrieff	Chris Brown
Director, Scott Moncrieff	Karen Jones
Head of Internal Audit, RSMUK	Marc Mazzucco

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

David McConnell welcomed everyone to the meeting. There were no apologies to be noted.

David McConnell advised that items 16, 18 and 19 were being presented as draft items with finalised versions being presented at a special Audit Committee on 2 July 2020 directly followed by a Board Meeting for final approval and sign off.

The deadline for accounts signing this year has been extended due to the Covid19 situation from 30 June 2020 to 30 September 2020, with external audit work and accounts completions both much affected by remote working and the other demands of addressing the consequences of the current crisis.

David McConnell informed members that it is proposed that at today's meeting the Audit Committee receive the Accounts for review and comment with a report from Scott Moncreiff which is a shortened version of the Annual Audit Report. This report will contain the clear audit certificate and confirm that there are no matters which should prevent approval and signing of the accounts. However as this report (ISA 260) is in draft the Audit Committee can only recommend the Accounts to the Board for signing subject to the ISA 260 being produced in final form with no further emerging matters, the finalised ISA 260 will be available in advance of the 2 July 2020 Audit Committee and Board Meetings.

The presentation of the Patients Funds Annual Accounts will be delayed with an update to be provided under any other business.

2 CONFLICTS OF INTEREST

Tom Hair noted a conflict of interest as the Procurement Manager and author of the Waiver Report presented at item 20. The Committee noted the disclosure.

3 MINUTES OF THE PREVIOUS MEETING

The Minutes of the previous meeting held on 26 March 2020 were approved as an accurate record.

4 MATTERS ARISING – ACTION PLAN UPDATE

Progress was noted on the Minute action points with all items either complete; not due for completion or delayed due to Covid19 restriction, with the exception of action 10 for which work is ongoing.

INTERNAL AUDIT

5 INTERNAL AUDIT ANNUAL REPORT 2019/20

Marc Mazucco and Sue Brooke presented the Internal Audit Annual Report for the period 2019/20 to members. A correction was noted on page 1 which should read 2020 and not 2019. The report provided an annual internal audit opinion based upon and limited to the work performed on the overall adequacy and effectiveness of the Hospital's risk management, control and governance processes, with the positive opinion contributing to the organisation's annual governance reporting.

Sue Brooke advised the Committee that management and staff were always willing to help and provide input during audits and with the completion of recommendations.

Appendix A provided the annual opinions; Appendix B gave a summary of the audit work completed with the assurance level attained also noted and Appendix C provided members with the opinion classification.

Brian Moore welcomed the positive report from internal audit and asked if the status or direction of the Rostering of Workforce audit findings are currently stalled due to Covid19 restrictions and if so when work on this would recommence.

In response, Gary Jenkins advised that helpful discussions with staff on aligning to safe staffing legislation has taken place however, as noted, other matters have superseded taking forward all findings and this will resume in a phased way once allowed by the easing of restrictions.

Sue Brooke confirmed that a high number of the actions/recommendations from this audit are aligned to the new safe staffing legislation, which has now been delayed nationally by one year in light of Covid19.

Members noted that the Governance Statement reflects the partial assurance achieved for the Payroll Audit.

Members noted the Internal Audit Annual Report for 2019/20.

6 INTERNAL AUDIT PLAN FOR 2020/21

Marc Mazzucco presented an update to Members on the Internal Audit Plan and Updated Strategy for 2020/21, the plan reflecting the changes agreed to the dates of some audits which allows for off site working to be undertaken during the current restrictions, with onsite working being commenced later in the year when allowed.

Bill Brackenridge asked if the audit of the new clinical model would still be possible, given the change in planned timescales resulting from the current Covid 19 developments.

Gary Jenkins advised that as a result of current restrictions the Hospital is working within an alternative and interim clinical model at present and agreed that with Robin McNaught, he would discuss with Internal Audit options for addressing any further changes to the audit plan.

ACTION: GARY JENKINS / ROBIN McNAUGHT / RSM UK

Terry Currie concurred that either an internal review or internal audit reflecting on how the interim clinical model impacted on the intended clinical model should be considered.

Marc Mazucco advised that RSMUK are aware that a significant amount of flexibility will be required with all audit plans this year in light of the restrictions and necessary changes to working practises arising from Covid19. The scheduled date for the Clinical Model Audit is March/April 2021 and advised that as we progress through the year an assessment on future audit plans will be made with any updates presented to the Committee for approval.

Members agreed that going forward the quarterly meeting with Sue Brooke; Robin McNaught and David McConnell be arranged 3 weeks in advance of each Committee to allow a review/assessment of the internal audit plan. In line with this timing, Robin McNaught will also consult with Gary Jenkins and Terry Currie to ensure up-to-date with the plan.

ACTION: FIONA HIGGINS

Members approved the internal Audit Plan and updated strategy for 2020/21 and noted the flexibility required going forward.

7 INTERNAL AUDIT TRACKING REPORT

The Committee received and noted the tracking report from RSMUK in relation to management actions taken forward in response to internal audit recommendations. Of the 18 actions reviewed three are not yet due for implementation and the other actions remain unimplemented for the following reasons:

- Two are reliant on training being provided as part of the risk management review. This has been delayed due to Covid19 restrictions.
- An action from the Payroll Audit requires updates from several members of staff and onsite testing to confirm completeness, again this is not possible at present due to Covid19 restrictions.
- Two actions are from the Rostering and Scheduling of Workforce Review on the enactment of safe staffing legislation, the implementation of this legislation has been paused as part of the national response to Covid19.

Members noted the reasons set out above for the outstanding actions all of which are outwith the control of the Hospital.

David McConnell asked that the useful supporting information contained within section 5 be included in the detailed table for future reports and Marc Mazucco agreed to action this.

ACTION: MARC MAZUCCO

Gary Jenkins advised that, where there was a nil response from staff, despite the actions not being possible due to Covid19 restrictions, a response should still have been provided to internal audit and that this would be addressed.

ACTION: GARY JENKINS

Members noted the update of the internal audit action tracker.

8 INTERNAL AUDIT ACCOUNTS PAYABLE REPORT

Marc Mazucco presented the report on the Accounts Payable internal audit, advising that the Hospital utilises National Services Scotland (NSS) to process creditor payments on its behalf. The audit produced a positive opinion with the following comments being made:

- Good practice was evident
- Electronic authorisation embedded into financial systems
- Appropriate annual reviews undertaken
- Board reports contain a good mix of financial narrative and content

Key areas for improvement:

- The Scheme of Delegation fails to identify who can authorise batch payments, such as BACS, and the Standing Financial Instructions do not set out the end to end process from requisition to payment of invoice
- Exception reports are not utilised to identify possible anomalies in the payment runs

Robin McNaught thanked internal audit for how they had addressed the challenges they faced in conducting the audit, utilising remote working. He advised that the points raised would be addressed promptly. In relation to the expiry of the NSS SLA, Mr McNaught assured the Committee that there would be no adverse impact. NSS are aware that this has been raised by internal audit and have assured the Hospital that conclusion of the SLA is forthcoming.

Members noted the content of the Accounts Payable Audit.

9 INTERNAL AUDIT CLINICAL OBSERVATIONS REPORT

Marc Mazucco presented the report on the Clinical Observations internal audit, advising that clinical observation follows guidance issued by Healthcare Improvement Scotland (HIS) in 2019 that aims to provide close monitoring of and engagement with someone who needs, for a period, intensive care and support. The audit produced reasonable assurance, and medium priority actions were raised in relation to the undernoted:

- Completion of patient records in RiO
- Implementation and monitoring of actions
- Sharing of new patient care plan
- Establishing a forum for reflecting on lessons learned

Key findings included:

- There is a Gap Analysis with supporting action plan which supports the noted areas for improvement, however the action plan was incomplete and it was not certain which forum was monitoring completion of these actions
- Patients not always provided with information in relation to observation, this is being addressed with the development of a patient version of the care plan
- RiO not always updated to reflect actions and decisions taken
- Compliance Audits undertaken by Clinical Effectiveness have accompanying action plans however these do not detail completion dates or owners
- No forum in which to discuss or share lessons learned from practices undertaken

Gary Jenkins responded by advising that immediate digital transformation can be used to address some of the key points noted.

Terry Currie highlighted the staffing resources required for clinical observations which did not appear to be covered within the audit. The additional staffing costs incurred by the Hospital due to observation levels can be significant and it would be helpful for the Committee to understand and be assured that a robust decision making process is in place for determining observation levels and the subsequent number of staff required for each observation level.

Sue Brooke advised that the audit touched on this and could be found on pages 5 and 6 of the report. However internal audit are not in a position to advise on the correct staffing numbers, as this would be a clinical decision – the audit did look at recording of this and gaps were noted.

Gary Jenkins advised that a policy is in place for observations and seclusions however a tightening and validation of the process may be required to ensure better governance and he agreed to provide reassurance to the Audit Committee at its next full meeting that a robust governance process is in place.

ACTION: GARY JENKINS

ANNUAL REPORTS FROM GOVERNANCE COMMITTEES

10 CLINICAL GOVERNANCE COMMITTEE - ANNUAL REPORT 2019/20

The Committee received the annual report from the Clinical Governance Committee for 2019/20, and agreed that this detailed report provided assurance that the Committee was fulfilling its remit, and that adequate and effective clinical governance arrangements were in place throughout the year.

A minor change to the report to amend membership was noted with Maire Whitehead's term ending on 29 February 2020 and Brian Moore's term commencing on 1 February 2020. This change will be made in advance of the report being submitted to the Board at its meeting this afternoon.

ACTION: MARGARET SMITH

Members received and noted the annual report which had been presented to the Clinical Governance Committee at its meeting in May 2020 and will be presented to the Board this afternoon for approval.

11 STAFF GOVERNANCE COMMITTEE - ANNUAL REPORT 2019/20

The Committee received the annual report from the Staff Governance Committee for 2019/20. The Chair of the Staff Governance Committee, Bill Brackenridge, summarised this for Members who noted that the report provided assurance that the Committee was fulfilling its remit and that adequate and effective staff governance arrangements were in place throughout the year.

Members received and noted the annual report which had been presented to the Staff Governance Committee at its meeting in May 2020 and will be presented to the Board this afternoon for approval.

12 REMUNERATION COMMITTEE - ANNUAL REPORT 2019/20

The Committee received the annual report from the Remuneration Committee for 2019/20. The Chair of the Committee, Terry Currie, provided an overview of this report which demonstrates that the Committee has discharged its responsibilities.

Members received and noted the annual report which will be presented to the Board this afternoon for approval.

13 AUDIT COMMITTEE - ANNUAL REPORT 2019/20

The Audit Committee received its Annual Report for consideration and approval. As Chair, David McConnell provided an overview of the report and Members were content to approve the report as giving assurance that the Committee had met its remit and was satisfied that internal controls are adequate to ensure that the Board can achieve its policies, aims and objectives.

A minor change to the report to add Brian Moore with his term commencing on 1 February 2020 will be made in advance of the report being submitted to the Board at its meeting this afternoon.

ACTION: MARGARET SMITH

Members received and noted the annual report which will be presented to the Board this afternoon for approval.

14 NATIONAL SINGLE INSTANCE (NSI) AND NSS SERVICE AUDITS

The Committee received a report to provide an update on the service audits carried out on the NSS National IT Services Contract, by KPMG and National Single Instance (NSI) Finance System, by BDO UK. Members were advised that NHS Ayrshire and Arran are the host Board for NSI.

In relation to the two non high risk exceptions identified within the NSI audit Robin McNaught assured members that following consultation with both Scott Moncrieff and at the NHS Director of Finance meetings a consistent approach to the wording of disclosure had been agreed and will be reflected by each Board in their Governance Statements.

Chris Brown advised that this had also been discussed at an Audit Scotland meeting where it was agreed that a consistent but not a prescribed form of words, taking into account the different service audits that Boards use and differing impact, would be acceptable, and advised that each Board required a disclosure.

Members were assured that these are the same control issues identified in previous audits, so there are no concerns to highlight, however as this was the first time the audit had been undertaken by RSMUK a slightly different approach had been taken.

Both NSS and NHS Ayrshire and Arran have provided Boards within copies of their Service Audits so that Boards can gain assurance of the operation of systems on their behalf and Robin McNaught advised the Committee that no high risk recommendations were identified. Full reports are available on request.

Members noted the opinions on the reports.

15 AUDIT SCOTLAND NATIONAL REPORTS

The Committee received a report to provide an update of the recommendations made following publication of Audit Scotland National Reports published since the previous Audit Committee. There have been two Audit Scotland Reports issued, with one being relevant to the State Hospital and the other in relation to General Medical Services Contract.

The report summarised the content of the NHS in Scotland – October 2019 which provided an update on the annual performance of the NHS and its future plans. A full copy of the report is available on the Audit Scotland website and members were encourage to read this. The main highlights from the report are in relation to savings targets and challenges in maintaining services with current funding.

Members noted the receipt of the national reports.

EXTERNAL AUDITS

16 EXTERNAL AUDIT ANNUAL REPORT TO THE BOARD AND THE AUDITOR GENERAL FOR SCOTLAND

The Committee received a draft report from Scott Moncrieff for the year ending 31 March 2020. Chris Brown led Members through the detail of the draft report, which was presented in an updated format. An extended deadline of end September 2020 has been agreed for annual reporting and accounts , reflecting the current challenges for this year's audit due to the Covid19 crisis. The report, as advised by David McConnell at the start of the meeting, is in draft format at present with the finalised version being presented to the 2 July 2020 Audit Committee and Board.

The draft report includes an unqualified opinion on the financial statements; regularity and other prescribed matters.

Chris Brown highlighted to members Note 1 Accounting Policies 1.27, Key sources of judgement and estimation uncertainty of the financial statements, which describes the effects of a material uncertainty, caused by Covid19, on the property values.

The draft report notes that the Board had achieved all of the key objectives within financial sustainability, financial management, governance and transparency as well as value for money. The auditor's report was unqualified in all respects. There was an addition of one key risk around Covid19 as detailed at page 6 of the report. In response to this risk a number of potential areas where there is a risk of material misstatement to the financial statements and/or audit opinion have been included:

- Property valuations
- Content of the annual report and accounts
- Access to audit evidence
- Timescale/administrative process

Chris Brown advised that in relation to property valuations BNP Paribas used annual indices all of which were published in advance of Covid19 and as such they now advise that there is material valuation uncertainty around valuation and property within the accounts. This has meant that the Auditors have included an Emphasis of Matter paragraph in their opinion on the accounts. In response to a question from David McConnell, Mr Brown confirmed that the treatment of this matter was consistent across all affected NHS Boards.

Chris Brown also confirmed that in relation to content of the annual report and accounts, the Board took the decision to include a reference to the valuation uncertainty in the performance analysis section of the Performance Report and in the Accountability Report.

The report confirmed that Scott Moncrieff received all audit evidence requested to allow formation of audit opinion.

The changes to timescales and the administrative process were detailed at paragraph 30 to 32 which notes the approval of the extension of the annual account deadline to 30 September 2020. There is a requirement for a 2nd partner review to be undertaken, in addition to a number of additional audit completion processes and Chris Brown assured members that the finalised report will be available for the 2 July 2020 Audit and Board meeting.

Members noted the draft report, a finalised version of which will be presented to the Audit Committee at its meeting on 2 July 2020.

17 TO RECEIVE AND NOTE EXERNAL AUDITOR APPOINTMENT

Robin McNaught presented a report advising that the Board's external auditors, currently Scott Moncrieff, are appointed on a 5 year cycle by Audit Scotland as part of a national tendering exercise. The 5 year period has recently been reviewed due to the current Covid19 crisis and an extension agreed to the current tender to 2021/22.

Members noted the extension of the external audit appointment of Scott Moncrieff to 2021/22.

STATUTORY ANNUAL ACCOUNTS

18 STATUTORY ANNUAL ACCOUNTS

The Committee received the Board's Annual Accounts, presented in the format directed by the Scottish Government. An addition to the accounts will be made at page 11 to show Lindsay Thomson's connection to Edinburgh University and Tom Hairs connection to the Credit Union.

ACTION: MARGARET SMITH

Robin McNaught provided a detailed summary, and highlighted the property valuation section on page 50 as discussed at item 16. He thanked the Finance Team for their excellent work, and acknowledged the recognition of this from the external audit report, which would be cascaded to staff. The accounts had been reviewed in full by Scott Moncrieff as external auditors, and the draft annual audit report from Scott Moncrieff includes an unqualified opinion on pages 30 to 31.

Robin McNaught advised that the Performance Report (pages 2 to 8) gave the main financial indicators, and confirmed that the Board was within budget for its revenue and capital limits and noted the current Covid19 crisis and its impact.

The Accountability Report i(pages 9 to 13) include the Corporate Governance Report; Statement of Health Board Members Responsibilities and the statutory compliance statement with regard to Chief Executive responsibilities.

The Governance Statement (pages 14 to 20) covers internal controls and risk assessment, and details the governance committees, and notes that the overall structure and wording remained similar to previous years, with the addition of the earlier noted disclosure on NSS Internal Audit Service Audits on page 20.

Pages 21 to 29 of the report detailed the remuneration for the year for senior staff, in the format consistent with last year which splits remuneration and pension details into two tables. As with prior years, the report includes fuller staff costs disclosures, including the gender breakdown of directors, senior managers and staff.

The Parliamentary Accountability Report on page 30 is unchanged from last year and gives disclosure on losses and special payments, and our basis of charging others for our services. This report along with the Accountability Report and Parliamentary Report are signed solely by the Chief Executive.

Pages 31 to 34 are the unqualified audit report from Scott Moncrieff, which has been amended as highlighted with the inclusion of the Emphasis of Matter paragraph re the uncertainties notified regarding the indexation applied to our properties during the year with a full cyclical valuation due in 2020/21.

Pages 35 to 39 are the principal financial statements – Statement of Comprehensive Net Expenditure, Summary of Resource Outturn, Statement of Financial Position (formerly the Balance Sheet), Cashflow Statement and Statement of Changes in Taxpayers' Equity, showing the breakeven revenue position. Formats and presentation of these are generally unchanged from prior year, with the Finance Director and Chief Executive signing the Statement of Financial Position on page 36.

Pages 40 to 50 cover accounting note 1 – Accounting Policies, these are consistent from prior years, and were approved at the Audit Committee meeting in April 2020. The main change being inclusion at 1.27 on page 40 of the detail on the BNP Paribas property indexations referred to earlier.

Pages 51 to 70 provide further detail on some of the accounting figures with statutory breakdown disclosures, formatting of which is mainly unchanged from 2019.

Subject to the minor amendments required, the Audit Committee agreed that the report on the annual accounts for the year ended 31 March 2020 be submitted to the Audit Committee on 2 July 2020 for consideration. The July Audit Committee will review the relevant reports at that date and as appropriate recommend the annual accounts to the Board for approval on the same date.

ANNUAL AUDIT COMMITTEE ASSURANCE STATEMENT TO THE BOARD
19 ANNUAL AUDIT COMMITTEE ASSURANCE STATEMENT

The Committee received a report recommending that it provides the Board with a statement of assurance to allow the approval for signing of the Performance Report, the Accountability Report as well as adoption of the Annual Accounts for the year ending 31 March 2020. This will now take place on 2 July 2020 once the final reviews are concluded by Scott Moncrieff.

It was noted that the Committee had received and considered the annual Internal Audit Report as well as reports and assurances from the Director of Finance and Performance Management and the Chief Executive Officer. The Audit Committee had also received the annual reports from the Clinical Governance Committee, the Staff Governance Committee and the Remuneration Committee.

Members noted the minor amendments required to the governance committee annual reports as well as the annual accounts and the auditor's report and would consider the provision of the Assurance Statement in full at the meeting on 2 July 2020.

OTHER ISSUES
20 WAIVER OF SFIs TENDERING REQUIREMENTS

The Committee received a report from the Director of Finance and Performance Management, to outline any instance during 2019/20 whereby the Chief Executive and Director of Finance and Performance Management have agreed to waive the requirement for competitive tendering or quotations should they jointly agree that it is not possible or desirable to undertake same due to timescale, specialist expertise, completion of an existing project, or a supply continuity benefit whilst giving regard for all circumstances, and in accordance with Standing Financial Instructions (SFIs).

The Committee were asked to note that each case was closely reviewed to ensure that the use of a waiver was valid. The instances when one or more of these exceptions has been applied in the year to March 2020 were attached to the paper for the Committee's information. The total value of instances, having risen in 2018/19, fell again in 2019/20, and the Committee were asked to note that each case is closely reviewed to ensure that the use of a waiver is valid. As is generally expected for these waivers, the main items in the year related to IT licensing, maintenance and service support.

The Committee noted the use of waivers for tendering.

21 FRAUD UPDATE

A report was submitted by the Director of Finance and Performance Management to provide an overview on fraud allegations and any notification received from Counter Fraud Services.

A significant number of alerts due to Covid19 had been issued since the last report and these were summarised within the report, all having been reviewed and circulated as appropriate with all newly reported approaches noted. One fraud matter remains open from 2019/20 with review to conclude, all other matters are closed having been concluded satisfactorily with no further action required. The Head of Service at CFS was due to present us with his annual update in March, but this will now require to be rescheduled.

Also requested for approval by the committee is a letter to the Scottish Government confirming that there were "no significant issues of fraud in 2019/20 requiring notification to Health & Social Care Assurance Board" (formerly the "Health and Wellbeing Audit and Risk Committee" the letter requires approval of the Committee and will be signed by David McConnell, Chair.

The Committee noted the alerts circulated by Counter Fraud Services in the last quarter and noted no updates on fraud allegations. Approval was also given to the signing of the letter to the Health and Social Care Assurance Board.

22 FRAUD ACTION PLAN

The Committee received and noted the paper which provided an update on Board engagement with Counter Fraud Services (CFS). The report detailed that all matters are on schedule or complete. Dates for our Annual Meeting with CFS and the proposed Cybercrime Presentation are on hold due to Covid19 restrictions. A minor amendment to the report was noted on appendix 1 where the heading date should read May 2019 and not 2017, appendix 1 provided details of ongoing items and appendix 2 summarised the top 10 Fraud Risks identified from the Fraud Risk Assessment as updated in May 2019, which were unchanged from the last reporting.

The Committee noted the progress on engagement activities; noted the update on Communication; reviewed the Fraud Action Plan (Appendix 1) and noted the review of the Top Ten Risks identified from the FRAM (Appendix 2, which had been agreed and reviewed with Head of CFS in March 2020 and to be fully reviewed in the new financial year 2020/21.

23 SUMMARY OF LOSSES AND SPECIAL PAYMENTS

The Committee received a report from the Director of Finance and Performance Management, which provided an annual review of the Board's register of losses and special payments. The paper summarised losses and special payments for the year and noted the decrease from the previous year, there being no significant elements requiring highlighting to the Committee.

The Committee were content to note the summary of recorded losses and special payments.

24 ANY OTHER BUSINESS

Patient Funds Accounts
As advised at the introduction the Patient Funds Accounts are delayed due to the inability yet to allow Wylie and Bisset on site. Wylie and Bisset are the independent auditors who undertake the patient fund audit on behalf of the Hospital. It is anticipated that the audit review will take place in July or August with completion in line with the new deadline of 30 September 2020. It may be necessary to arrange an additional meeting to approve the Patient Accounts, a decision on this will be taken closer to the completion date.

25 DATE AND TIME OF NEXT MEETING

An additional meeting for approval of the annual accounts will take place on 2 July 2020 via Microsoft Teams.

The next full meeting of the Audit Committee will take place on Thursday 8 October 2020 at 9.45am via Microsoft Teams

THE STATE HOSPITALS BOARD FOR SCOTLAND

DRAFT Minutes of the meeting of the Audit Committee held on Thursday 2 July 2020 at 11.00am via Microsoft Teams

PRESENT:	
Non Executive Director	David McConnell (Chair)
Employee Director	Tom Hair
Non Executive Director	Bill Brackenridge
Non Executive Director	Brian Moore
IN ATTENDANCE:	
Internal	
Chief Executive	Gary Jenkins
Board Chair	Terry Currie
Finance and Performance Management Director	Robin McNaught
Human Resources Director	John White
PA to Finance and Performance Management Director and Director of Security, Estates and Facilities	Fiona Higgins
Board Secretary	Margaret Smith
PA to Chair and Chief Executive	David McCafferty
External	
Director, Scott-Moncrieff	Chris Brown

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

Apologies were received from Marc Mazucco and Monica Merson. David McConnell welcomed everyone to the meeting which had been called to complete the Hospital's Annual Accounts for the period 2019/20. The governance and annual reports along with a draft set of accounts and associated reports were presented to the Committee at its meeting on Thursday 18 June 2020.

2 CONFLICTS OF INTEREST

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

EXTERNAL AUDIT

3 EXTERNAL AUDIT ANNUAL REPORT TO THE BOARD AND THE AUDITOR GENERAL FOR SCOTLAND

Members received from Chris Brown, the finalised External Audit Annual Report for 2019/20 to The State Hospitals Board for Scotland and the Auditor General for Scotland. It was noted that the report summarised the work of Scott-Moncrieff throughout the year and their findings in relation to their audit of the financial statements, corporate governance arrangements and performance management arrangements.

Chris Brown summarised the report and the key points of note in relation to the audit, this had mostly been discussed at the meeting on 18 June however this report was now in its finalised version and addresses those matters flagged as outstanding in the previous draft. It included one minor change regarding the previously outstanding issue relating to NSS's Service Audit - Health Service Report and Statutory Reports. This had now been received, concluded satisfactorily, and is noted within the external audit annual report with no further action required.

Chris Brown advised that KPMG had undertaken the NSS Service audit this year resulting in a slight change to the scope and approach and the resultant qualification. The underlying issues raised were the same as those raised in previous years' reports so there was no significant risk to the State Hospital accounts and this is now reflected in the Scott Moncreiff Annual Report.

As with all NHS Boards an Emphasis of Matter paragraph has been included in the auditor's opinion on the annual accounts in relation to property valuations. This resulted from changes in market conditions as a result of Covid 19 . A requirement of the accounting standard is to ask valuers to undertake a sensitivity analysis due to this material uncertainty and to note any impact on valuation and ensure this is reflected within the accounts. This has not been actioned within the accounts and the audit report includes a recommendation to complete this in future accounts. Chris Brown assured members that this is not a material issue and is the approach that has been taken across the NHS in Scotland, with all external auditors including an additional paragraph in their opinions. A reference has also been added to the State Hospital's accounts and letter of representation.

Members noted the External Audit report 2019/20 to The State Hospitals Board for Scotland and the Auditor General for Scotland and expressed their thanks to Chris Brown and Karen Jones for the work undertaken, noting the additional challenges which the restrictions resulting from Covid 19 had placed on the auditors and the hospital's finance team in undertaking the final audit and accounts.

STATUTORY ANNUAL ACCOUNTS
4 ANNUAL REPORT AND ACCOUNTS FOR YEAR ENDED 31 MARCH 2020

Members received the Annual Report and Accounts for the year 2019/20 which had been reviewed by External Auditors, Scott-Moncrieff.

Robin McNaught summarised the report, highlighting the minor changes as advised by Chris Brown, Scott Moncreiff at item 3 and advised members that a full property evaluation is scheduled for next year which will allow the Hospital to be compliant with the recommendation made. Members also noted an update at pages 10 and 11 in relation to members' interests for Tom Hair and Lindsay Thomson and the change to the signature dates to 2 July 2020 and concluded by advising that the Hospital had achieved all its financial targets during the year 2019/20.

Brian Moore asked for clarity on the variance of the security enhancement costs which are noted on page 5 as £8.7m yet on page 65 as £9.6m. Robin McNaught advised that the figure quoted on page 5 of the accounts excludes VAT and members agreed that a further update to the accounts at page 5 to highlight that £8.7m (excludes VAT) be made in advance of presenting to the Board for approval.

ACTION: FIONA HIGGINS

Terry Currie highlighted that the cost projections for the Security Refresh Project had been subject to movement with the overall projected figure advised in the latest report to the Board from the Project Team including staffing costs however the figure quoted within the annual accounts is the amount of the contract which does not include staffing costs.

Members joined Robin McNaught in expressing thanks to Scott-Moncrieff and the Hospital Finance Team for their work in the preparation of this year's Annual Accounts under the challenging restrictions resulting from Covid 19.

Members reviewed and recommended the statutory annual accounts for 2019/20 to the Board for final approval.

5 AUDIT COMMITTEE ANNUAL ASSURANCE STATEMENT TO THE BOARD

Members received a report from Robin McNaught in respect of the Annual Audit Committee Assurance Statement to the Board for 2019/20.

Robin McNaught summarised the report and members noted that the Assurance Statement would give specific assurance that all relevant Governance Committee reports had been received together with appropriate assurances from our internal auditors and an unqualified audit opinion from our external auditors. Following upon that, the Performance Report, Accountability Report and the accounts themselves can be put forward for approval by the Board.

Members agreed to recommend that the Board:

Adopt the Annual Accounts for the year ended 31 March 2020 and approve submission to the Scottish Government Health and Social Care Directorate, *and*

Authorise:

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

Members approved the Annual Audit Committee Assurance Statement 2019/20 for submission to the Board.

OTHER ISSUES
6 ANY OTHER BUSINESS

Patient Funds
Members noted that due to the restrictions of Covid 19 there has been a delay to the preparation of the Patient Funds Annual Accounts, these are expected to be completed by the accounts deadline of 30 September 2020. However the next Audit Committee meeting is scheduled to take place on 8 October 2020, as such Robin McNaught will confirm with Wylie and Bisset if an extension to the approval of the Patient Funds Accounts can be delayed to 8 October 2020. If not an additional Audit Committee will be arranged to deal with the Patient Funds.

ACTION: ROBIN McNAUGHT

7 DATE AND TIME OF NEXT MEETING

The next meeting would take place on Thursday 8 October 2020 at 9.45am in the boardroom.

Board Report 20/78

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 October 2020
Agenda Reference:	Item No: 23
Sponsoring Director:	Finance & Performance Director
Author(s):	Risk Management Team Leader
Title of Report:	Corporate Risk Register – Very High/High/Medium risks
Purpose of Report:	For Discussion

1 SITUATION

This paper is prepared to provide oversight to the Board of the medium, high and very high risks featuring on the Corporate Risk Register and to provide assurance that these are being addressed.

2 BACKGROUND

This report provides an update on Very High, High and Medium Corporate Risks that are currently recorded on the Corporate Risk Register. The Corporate Risk Register was presented to the Audit Committee in October and is also a standing agenda item on the quarterly Risk, Finance and Performance Committee.

3 ASSESSMENT

Current Corporate Risk Register is detailed within Appendix A.

Changes:
FD95 – Lack of on-call IT arrangements which was graded as low has been removed from the CRR. This risk will now be dealt with on the department's Local Risk Register. This change was agreed by Audit Committee on 8 October.

SD51 has been reduced to Major x Unlikely and target adjusted to Major x Rare, changing the grading from high to medium upon review of existing control measures.
SD52 has been reduced to Moderate x Unlikely and target adjusted to Moderate x Rare upon review of existing control measures.
SD53 has been reduced to Extreme x Rare which is at target level. This also reduced the risk rating from high to medium upon review of existing control measures.
HRD112 has been increased to Major x Possible also increasing the risk rating from medium to high due to the impact of Covid-19 on ability to provide training.

There is 1 Very High risk:

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

The 5 following risks are graded as High:

MD30 Failure to prevent/mitigate obesity
ND70 Failure to utilise our resources to optimise excellent patient care and experience
*ND71 Failure to assess and manage the risk of aggression and violence effectively
FD97 Unmanaged smart telephones' access to The State Hospitals information and systems.
HR112 Compliance with Mandatory PMVA Level 2 Refresher Training

The following 23 risks are graded as Medium

*CE10 Severe breakdown in appropriate corporate governance
*CE11 Risk of patient injury occurring which is categorised as either extreme injury or death
CE12 Failure to utilise appropriate systems to learn from prior events internally and externally
MD32 Absconsion of patients
*MD33 Potential adverse impact arising from clinical presentation out of hours with no doctor on site (5pm - 6pm)
*MD34 Lack of out of hours on site medical cover
MD35 Non-compliance with Falsified Medicines Directive
*SD50 Serious Security Incident
SD51 Physical or electronic security failure
SD52 Resilience arrangements that are not fit for purpose
*SD53 Serious security breaches (eg escape, intruder, serious contraband)
SD54 Climate change impact on The State Hospital
SD55 Negative impact of EU exit on the safe delivery of patient care within The State Hospital
SD56 Water Management
ND72 Failure to evolve the clinical model, implement and evidence the application of best practice in patient care
ND73 Lack of SRK trained staff
FD90 Failure to implement a sustainable long term model
FD91 IT system failure/breach
FD93 Failure to complete actions from Cat 1/2 reviews within appropriate timescale
FD94 Inadequate data centre
*FD96 Cyber Security/Data Protection Breach due to computer infection
HRD110 Failure to implement and continue to develop the workforce plan
*HRD111 Deliberate leaks of information

*target risk met

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

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

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

*being reviewed weekly at present

Risk distribution of other risks are as follows:

	Negligible	Minor	Moderate	Major	Extreme
Almost Certain				CE14	
Likely			ND70	MD30	
Possible			CE12, SD50, SD54, ND72, ND73, FD91, FD93, FD94	ND71, FD97, HRD112	
Unlikely			MD33, MD35, SD52, SD55, FD90, FD96, HRD110	MD34, SD56, HR111, SD51	
Rare			CE13	MD32	CE10, CE11, SD53

4 RECOMMENDATION

The Corporate Risk Register Very High/High/Medium Risk report is presented to the Board for discussion, and to request whether any amendment is required to existing risks and/or whether additional areas should be considered.

Author:
Nicola Watt
Risk Manager Team Leader
01555 842197

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	The Corporate Risk Register (CRR) supports the monitoring and review of corporate risks that could prevent TSH achieving its main aims and objectives.
Workforce Implications	The CRR monitors risks that could negatively affect the workforce. This ensures they are regularly reviewed and that control measures are in place.
Financial Implications	The CRR monitors financial risks that could affect TSH. This ensures they are regularly reviewed and control measures are in place.
Route To Board Which groups were involved in contributing to the paper and recommendations.	Requested through the Board Workplan. Reported through Risk, Finance & Performance Group, oversight through the Audit Committee
Risk Assessment (Outline any significant risks and associated mitigation)	Risk Assessments are detailed in paper and significant risks have been highlighted.
Assessment of Impact on Stakeholder Experience	No impact to stakeholder experience.
Equality Impact Assessment	This paper has been reviewed and there was no impact to any protected groups therefor an EQIA was 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).	The paper has been reviewed and The Fairer Scotland Duty is not applicable.
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.

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
Corporate CE 10	Reputation	Severe breakdown in appropriate corporate governance	Extreme x Possible	Extreme x Rare	Extreme x Rare	Chief Executive	Chief Executive	31/12/20	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	31/12/20	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	31/12/20	Risk, Finance & Performance Group	Y/Y	N/A	Quarterly
Corporate CE 13	Strategic	Inadequate compliance with Chief Executive Letters and other statutory requirements	Moderate x Unlikely	Moderate x Rare	Moderate x Rare	Chief Executive	Board Secretary	31/01/21	SMT	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	12/10/20	SMT	Y/Y		Weekly
Corporate MD 30	Medical	Failure to prevent/mitigate obesity	Major x Likely	Major x Likely	Moderate x Unlikely	Medical Director	Lead Dietitian	31/10//20	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	30/11/20	SMT	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	30/11/20	SMT	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	30/11/20	SMT	Y/Y	N/A	Quarterly
Corporate MD 35	Medical	Non-compliance with Falsified Medicines Directive	Moderate x Unlikely	Moderate x Unlikley	Moderate x Rare	Medical Director	Associate Medical Director	31/10/20	Medicines Committee	Y/Y	N/A	Quarterly

Corporate SD 50	Service/Business Disruption	Serious Security Incident	Moderate x Possible	Moderate x Possible	Moderate x Possible	Security Director	Security Director	30/11/20	SMT	Y/Y	N/A	Quarterly
Corporate SD 51	Service/Business Disruption	Physical or electronic security failure	Extreme x Unlikely	Major x Unlikely	Major x Rare	Security Director	Security Director	30/11/20	Audit Committee	Y/Y	Y/Y	Quarterly
Corporate SD 52	Service/Business Disruption	Resilience arrangements that are not fit for purpose	Major x Unlikely	Moderate x Unlikely	Moderate x Rare	Security Director	Security Director	30/11/20	SMT	Y/Y	N/A	Quarterly
Corporate SD 53	Service/Business Disruption	Serious security breaches (eg escape, intruder, serious contraband)	Extreme x Unlikely	Extreme x Rare	Extreme x Rare	Security Director	Security Director	30/11/20	Audit Committee	Y/Y	Y/Y	Quarterly
Corporate SD 54	Service/Business Disruption	Climate change impact on the State Hospital	Minor x Possible	Moderate x Possible	Minor x Possible	Security Director	Head of Estates and Facilities	30/11/20	SMT/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	30/11/20	SMT	Y/Y	N/A	Quarterly
Corporate SD 56	Service/Business Disruption	Water Management	Major x Unlikely	Major x Unlikely	Major x Rare	Security Director	Head of Estates and Facilities	31/10/20	Infection Control Committee	Y/Y	N/A	New
Corporate ND 70	Service/Business Disruption	Failure to utilise our resources to optimise excellent patient care and experience	Moderate x Possible	Moderate x Likely	Minor x Unlikely	Director of Nursing & AHP	Director of Nursing & AHP	31/10/20	SMT	Y/Y	Y/Y	Monthly
Corporate ND 71	Health & Safety	Failure to assess and manage the risk of aggression and violence effectively	Major x Possible	Major x Possible	Major x Possible	Director of Nursing & AHP	Director of Nursing & AHP	31/10/20	SMT	Y/Y	Y/Y	Monthly
Corporate ND 72	Service/Business Disruption	Failure to evolve the clinical model, implement and evidence the application of best practice in patient care	Moderate x Possible	Moderate x Possible	Moderate x Unlikely	Director of Nursing & AHP	Director of Nursing & AHP	31/10/20	SMT	Y/Y	N/A	Quarterly
Corporate ND 73	Service/Business Disruption	Lack of SRK trained staff	Moderate x Likely	Moderate x Possible	Moderate x Unlikely	Director of Nursing & AHP	Director of Nursing & AHP	31/12/20	PMVA Group and SMT	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	31/12/20	Audit Committee, RF&P Group & SMT	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	31/12/20	Information Governance Group & SMT	Y/Y	N/A	Quarterly
Corporate FD 93	Health & Safety	Failure to complete actions from Cat 1/2 reviews within appropriate timescale	Moderate x Possible	Moderate x Possible	Moderate x Unlikely	Finance & Performance Director	Head of Corporate Planning and Business Support	31/12/20	CMT, SMT	Y/Y	N/A	Quarterly
Corporate FD 94	Service/Business Disruption	Inadequate data centre	Moderate x Likely	Moderate x Possible	Moderate x Unlikely	Finance and Performance Director	Head of eHealth	31/12/20	SMT/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 Unlikely	Finance and Performance Director	Head of eHealth	31/12/20	SMT/Resilience Committee	Y/Y	N/A	Quarterly
Corporate FD 97	Reputation	Unmanaged smart telephones' access to The State Hospital information and systems.	Major x Likely	Major x Possible	Major x Unlikely	Finance and Performance Director	Head of eHealth	31/10/20	Information Governance Group & SMT	Y/Y	Y/Y	Monthly
Corporate HRD 110	Resource	Failure to implement and continue to develop the workforce plan	Moderate x Possible	Moderate x Unlikely	Minor x Rare	Interim HR Director	Interim HR Director	31/12/20	SMT	Y/Y	N/A	Quarterly
Corporate HRD 111	Reputation	Deliberate leaks of information	Major x Possible	Major x Unlikely	Moderate x Unlikely	Interim HR Director	Interim HR Director	31/12/20	SMT	Y/Y	Y/N	Monthly
Corporate HRD 112	Health & Safety	Compliance with Mandatory PMVA Level 2 Training	Major x Unlikely	Major x Possible	Major x Rare	Interim HR Director	Training & Professional Development Manager	30/09/20	H&S Committee	Y/Y	N/A	Quarterly

Very High Graded
Actions from those not at target level

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.

- As this is a developing situation control measures are being looked at daily through the established command centre. In progress work is being monitored by the Covid-19 Support Team.
- Guidance being updated on a daily basis and being relayed to staff as soon it is can be.
- Approach taken to re-establish services within the hospital. Risk assessments for each activity will take place based on infection control guidelines and public health advice.
- Proposal to reintroduce activities in the Skye Centre, some activities are beginning to resume.
- Corporate Risk Register risks being updated to include impact of Covid-19

High Graded
Actions from those not at target level

MD30 Failure to prevent/mitigate obesity

- Ongoing patient education and where appropriate restrictions/limits on additional food stuffs (snacks, takeaways, high energy food items and similar) being available out with meals in conjunction with 'Supporting Healthy choices' remit for those 'at high risk'.
- Workshop in January 2020 to scope work and changes required – step wise introduction of feasible changes post COVID pandemic.
- Review of cumulative effect of availability of food to patients and how this can be managed in a least restrictive manner to support patient's physical health.
- Increased accessibility of physical activity opportunities for all patients daily – move to national physical activity targets (min 150 minutes vs. 90).
- Increased education and training for staff around physical health needs – identified key support staff (trained and assistant proposed) to follow on from health champion posts in 2020 across the site supporting physical health matters.
- Ongoing implementation and audit of health and Wellbeing plans for 100% patients updated monthly and discussed at CPA's.
- Initiation of 'counterweight plus' (VLCD plans) in 2020 to targeted patients.
- Some of this work on hold due to COVID 19 pandemic.

ND70 Failure to utilise our resources to optimise excellent patient care and experience

- Recruitment to funded establishment
- Review of recruitment processes to streamline and minimise risks of gaps in workforce
- Review of roles and responsibilities regarding Nurse rostering and associated decision making
- Introduction of e-rostering platform
- Increase in staffing allocated to the nursing 'pool'

- Variation to shift pattern for new starts – 7.5 hour shift x 5 day
- Development of nursing element of workforce strategy
- Improved workforce information
- Recruitment of 'returners to practice.'

FD97 Unmanaged smart telephones' access to The State Hospital information and systems.

- Ongoing monitoring of increased security aspects of new phones introduced in 2019 – through 2020 – to ensure compliance and reduced likelihood of breach.

Medium Graded
Actions from those not at target level

CE12 Failure to utilise appropriate systems to learn from prior events internally and externally

- Await outcome of HIS notification process.

FD90 Failure to implement a sustainable long term financial model

- Review longer-term projections for sensitivities and potential budgetary pressures.

FD91 IT system failure/breach

- Increased use of DPIA to be encouraged and awareness raised.

FD93 Failure to complete actions from Cat 1/2 reviews within appropriate timescale

- Regular robust reporting arrangements required.

FD94 Inadequate data centre

- Replacement data centres in place April 2019 - now being closely monitored post-implementation. Further actions also now being addressed to introduce formal regular disaster recovery checking procedures (now underway in 2020 Qtr.1) and to reduce any identified unnecessary storage levels.

FD96 Cyber security/Data Protection breach due to computer infection.

At target level however:

- Cyber security training development ongoing.

SD52 Resilience arrangements that are not fit for purpose

- Increase frequency of testing programme.
- Completion of training plan for Incident Command.

SD54 Climate Change impact on the State Hospital

- Monitoring of climate change.
- Representation on NSS Sustainability Group (Head of Estates)
- Local sustainability group meetings.

SD55 Negative impact of EU exit on the safe delivery of patient care within The State Hospital

Complying with national guidance re: communication to staff

- Maintain links with partner agencies regarding ongoing developments.
- Weekly meetings to begin from December 2020 in line with National Guidance

SD 56 Water Management

- Remedial work identified in L8 Risk Assessments to be completed

MD32 Absconsion of patients
No actions identified to reduce to target level – will be highlighted to risk owner.

MD35 Non-compliance with Falsified Medicines Directive

- NHS Lothian verification procedures to be in place before TSH implements own FMD. Likely end 2020.
- Standalone software and scanner required for TSH from JAC
- Identify location and staffing requirements within TSH for verification and decommissioning. Suitable training will be delivered.
- Register with Securmed for database link
- Standard operating procedures will be developed for process and how to deal with any 'fake' medicines identified. These should however have been picked up earlier in the NHS supply chain. Single SOPs for Scotland proposed.

ND72 Failure to evolve the clinical model, implement and evidence the application of best practice in patient care

- Implementation of agreed changes to clinical service delivery model during 2020/21.

ND73 Lack of SRK trained staff

- Training of all ward nursing staff in use of SRKs as part of PMVA training.

HRD 110

- No actions identified to reduce to target level – will be highlighted to risk owner.

HRD111 – Deliberate leaks of information

- Explore the potential to utilise the metacompliance system to ensure that all staff read the 'Protecting Patient Confidentiality NHS Scotland Code of Practice.

HR112 Compliance with Mandatory PMVA Level 2 Training

- Risk assessment to be completed in relation to Level 2 PMVA training delivery arrangements during the Covid-19 pandemic.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 October 2020
Agenda Reference:	Item No: 24
Sponsoring Director:	Board Chair
Author(s):	Board Secretary
Title of Report:	Annual Schedule of Board and Sub Board Meetings – 2021
Purpose of Report:	For Decision

1 SITUATION

The Board requires to agree the schedule of meetings for 2021, and to make the dates of the board meetings publically available on its website.

2 BACKGROUND

The draft schedule of Board and Committee Meetings in 2021 has been circulated to all Board Members for comments and input.

3 ASSESSMENT

The draft Annual Schedule of Meetings for Board and Sub Board Committees in 2021 is attached as Appendix A.

There are no proposed changes to the usual pattern of the schedule for Board and Committee Meetings.

Of note, it is proposed that the Audit Committee and Board meeting on the same day in June 2021, to allow full review of the annual accounting process.

Further, that the Remuneration Committee should schedule three meeting throughout the year, timed to ensure that the Executive and Senior Manager appraisal process is fully supported. In accordance with its terms of reference, the Remuneration Committee may stand up further meetings should members consider this to be appropriate.

4 RECOMMENDATION

Members are asked to decide if the attached Annual Schedule of Meetings for 2021 should be adopted.

Author:
Margaret Smith
Board Secretary
01555 842012

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	To ensure the TSH Board and its standing committees has schedule of meetings in place and can fulfil its remit in 2021.
Workforce Implications	None considered
Financial Implications	None considered
Route To Board Which groups were involved in contributing to the paper and recommendations.	Board requested item through its workplan
Risk Assessment (Outline any significant risks and associated mitigation)	This reports mitigates the risk of board committees not being able to fulfil their remit, failure of attendance /quorum if a schedule Is not in place, failure to alert the public in good time to public board meetings.
Assessment of Impact on Stakeholder Experience	Stakeholders and wider public should be notified of the schedule of public board meetings.
Equality Impact Assessment	Not required
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	Not applicable
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One X There are no privacy implications. □ There are privacy implications, but full DPIA not needed □ There are privacy implications , full DPIA included.

The State Hospitals Board For Scotland

ANNUAL SCHEDULE OF MEETINGS - 2021

BOARD AND SUB-BOARD

MEETING	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEPT	OCT	NOV	DEC
BOARD*		**Thursday 25.02.21 9.45am**		**Thursday 22.04.21 9.45am**		**Thursday 17.06.21 12.30pm**		**Thursday 26.08.21 9.45am**		**Thursday 28.10.21 9.45am**		**Thursday 23.12.21 9.45am**
AUDIT COMMITTEE	**Thursday 21.01.21 9.45am**		**Thursday 25.03.21 9.45am**			**Thursday 17.06.21 9.45am**				**Thursday 07.10.21 9.45am**		
CLINICAL GOVERNANCE COMMITTEE		**Thursday 11.02.21 9.45am**			**Thursday 13.05.21 9.45am**			**Thursday 12.08.21 9.45am**			**Thursday 11.11.21 9.45am**	
STAFF GOVERNANCE COMMITTEE		**Thursday 18.02.21 9.45am**			**Thursday 20.05.21 9.45am**			**Thursday 19.08.21 9.45am**			**Thursday 18.11.21 9.45am**	
REMUNERATION COMMITTEE *		**Thursday 25.02.21**					**Thursday 1 July 2021**				**Thursday 25.11.21**	

* The Board and Remuneration Committee may also meet as and when required

2021

PUBLIC HOLIDAYS: *New Year* : Friday 1 January & Monday 4 January
Christmas : Monday 27 December & Tuesday 28 December
Easter : Friday 2 April & Monday 5 April
Autumn Holiday : Friday 24 September & Monday 27 September