THE STATE HOSPITALS BOARD FOR SCOTLAND

BOARD MEETING

THURSDAY 24 FEBRUARY 2022
at 10am, held by MS Teams
A G E N D A

1.	**Apologies**		
2.	**Conflict(s) of Interest(s)** To invite Board members to declare any interest(s) in relation to the Agenda Items to be discussed.		
3.	**Minutes** To submit for approval and signature the Minutes of the Board meeting held on 23 December 2021	For Approval	TSH(M)21/12
4.	**Matters Arising:**		
	Actions List: Updates	For Noting	Paper No. 22/01
5.	**Chair's Report**	For Noting	Verbal
6.	**Chief Executive Officer's Report**	For Noting	Verbal
10.15am	**RISK AND RESILIENCE**		
7.	**Covid 19 Response and Remobilisation:**		
a.	**Resilience Update** Report by the Chief Executive	For Decision	Paper No. 22/02 Paper No. 22/03
b.	**Finance Update** Report by the Director of Finance & eHealth	For Noting	
8.	**Corporate Risk Register** Report by the Director of Security, Resilience and Estates	For Decision	Paper No. 22/04
10.40am	**CLINICAL GOVERNANCE**		
9.	**Clinical Model Implementation – Progress Update** Report by the Medical Director	For Noting	Paper No. 22/05
10.	**Supporting Healthy Choices – Progress Update** Report by the Medical Director	For Noting	Paper No. 22/06
	*** BREAK 11.am to 11.30am***		

11.	**Quality Assurance and Quality Improvement** Report by the Head of Corporate Planning and Business Support	For Noting	Paper No. 22/07
12.	**Clinical Governance Committee** Approved minutes - meeting held 11 November 2021 Chair's Update – meeting held 10 February 2022	For Noting	CG(M)21/04
11.50am	**STAFF GOVERNANCE**		
13.	**Attendance Performance Report** Report by the Director of Workforce	For Noting	Paper No. 22/08
14.	**Whistleblowing: Quarter 3 Update** Report by the Director of Workforce	For Noting	Paper No. 22/09
15.	**iMatter Reporting** Report by the Director of Workforce	For Noting	Paper No. 22/10
16.	**Staff Governance Committee** Approved minutes - meeting held 18 November 2021 Chair's Update – meeting held 17 February 2021	For Noting	SG(M) 21/04
12.20pm	**CORPORATE GOVERNANCE**		
17.	**Corporate Objectives 2022/23** Report by the Board Secretary	For Decision	Paper No. 22/11
18.	**Finance Report to 31 January 2022** Report by the Director of Finance & eHealth	For Noting	Paper No. 22/12
19.	**Perimeter Security and Enhanced Internal Security Systems Project** Report by the Director of Security, Resilience and Estates	For Noting	Paper No. 22/13
20.	**Performance Report Q3 – 2021/22** Report by the Head of Corporate Planning and Business Support	For Noting	Paper No. 22/14
21.	**Remuneration Committee – Update** Report by the Board Secretary	For Noting	Paper No. 22/15
22.	**Any Other Business**		Verbal
23.	**Date of next meeting** 28 April 2022		Verbal
24.	**Proposal to move into Private Session, to be agreed in accordance with Standing Orders.** Chair	For Approval	Verbal
25.	**Close of Session and Reflection on Meeting**		Verbal

Estimated end at 1.pm

THE STATE HOSPITALS BOARD FOR SCOTLAND TSH (M) 21/12

Minutes of the meeting of The State Hospitals Board for Scotland held on Thursday 23 December 2021. Meeting conducted virtually by way of MS Teams and commenced at10am.

Chair: Brian Moore

Present:

Employee Director	Allan Connor
Non-Executive Director	Stuart Currie
Non-Executive Director	Cathy Fallon
Chief Executive	Gary Jenkins
Vice Chair	David McConnell
Director of Finance and eHealth	Robin McNaught
Non-Executive Director	Pam Radage
Director of Nursing, AHPs and Operations	Mark Richards
Medical Director	Lindsay Thomson

In attendance:

Head of eHealth	Thomas Best [Item 21]
Manager - Patent Advocacy Service	Rebecca Carr [Item 10]
Director of Workforce	Linda Davidson
Person Centred Improvement Lead	Sandie Dickson [Items 8 & 9]
Social Work Team Leader	David Hamilton
Information Governance and Data Security Officer	Ken Lawton [Item 22]
Head of Communications	Caroline McCarron
Head of Corporate Planning and Business Support	Monica Merson
Board Secretary	Margaret Smith [Minutes]
Chair – Patient Advocacy Service	Michael Timmons [Item10]
Director of Security, Resilience and Estates	David Walker

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

Mr Moore welcomed everyone to the meeting, and apologies were noted from Dr Sheila Howitt (Chair of the Clinical Forum).

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 meeting held on 28 October 2021 were agreed to be a full and accurate record of the meeting.

The Board:

1. Approved the minute of the meeting held on 28 October 2021: TSH(M)21/10.

4 ACTION POINTS AND MATTERS ARISING FROM PREVIOUS MEETING

The Board received the action list (Paper No. 21/89) and noted progress on the action points from the last meeting, with actions either being completed or progressed satisfactorily.

The Board:

1. Noted the updated action list.

5 CHAIR'S REPORT

Mr Moore provided an update to the Board in relation to his activities as Board Chair over the previous two-month period since the date of the last Board meeting.

He had held a helpful introductory meeting with Ms Donna Bell, Director of Mental Health with Scottish Government.

Mr Moore highlighted the great success of the Staff Excellence Awards which took place virtually on 30 November 2021, and which had included participation from patients as well as staff. The patient choir had performed, and this had been an excellent contribution to the event. Additionally, patients had been able to nominate staff for awards and this had been very welcome. A Staff Bulletin had been issued describing each of the awards, as well as celebrating the nominees and winners of each. The event had also provided an opportunity to celebrate staff who had achieved long service in the NHS, and to thank them for this service. Both Mr Moore and Mr Connor had been able to take part on the ceremony this year, and had presented awards; and Mr Moore noted that it worked well and felt inclusive as an event. He thanked Organisational Development colleagues for their work in organising the event and hoped that it may be possible for it to take place in person in 2022, and for more Non-Executive Board Members to take part.

He had also visited the Skye Centre Crafts and Design Centre, along with Mr Jenkins, and had been able to see patients' work, the quality of which was impressive, as well as to meet staff. Some pieces would be placed on display within the hospital. It was clear that this service was greatly beneficial for patients in their rehabilitation. Mr Moore had also attended the Clinical Forum on 23 November and appreciated this contact with the forum, which generated interesting discussion.

He also confirmed that he had continued to attend weekly National Board Chairs meetings, as well as weekly meetings with the Cabinet Secretary for Health and Social care (with NHS Chairs and Board Chief Executives). These meetings continued to have a focus on challenges in care delivery across Boards, and wider workforce issues. This latter issue clearly linked to current challenges within The State Hospital (TSH). In addition, Board Chairs had been kept appraised in respect of the prioritisation of service delivery by the Deputy First Minister, Mr Swinney, and NHS Scotland Director General, Ms Lamb.

Finally, Mr Moore noted the successes for The State Hospital in winning two national awards. He paid tribute to all involved in winning an "Innovation in Education" award from the Mental Health Nursing Forum, as well as the finance team which had won the National Boards award for the "Best Finance Team".

The Board:

1. Noted this update from the Chair.

6 CHIEF EXECUTIVE'S REPORT

Mr Jenkins provided an update to the Board on his activities and on key national issues as well as local updates, since the date of the last Board meeting. He noted his own involvement in the national framework meetings as described by the Board Chair, with the key pressure for TSH being staffing in terms of capacity and recruitment challenges within the national context. He highlighted the pressures within NHS Scotland and the significant pressure presented by the Covid-19 Omicron variant to the wider NHS in overall capacity in the context of delayed discharges from general hospitals and pressure on Emergency Care. Further, that NHS Scotland had clear booster vaccination targets and every effort was being made to deliver these.

He echoed the Chair's advice, and underlined the national guidance and escalation process, with guidance from the Deputy First Minister and Director General on the key priorities, challenges and risks for NHS Scotland at the present time. This included contingency planning especially within staffing (with use of redeployment, supplementary staffing, and focus on recruitment including students) as well as optimizing digital support of service delivery. Mr Jenkins confirmed that TSH was taking forward contingency planning at a local level fully in line with the national position. As part of this approach, there may be an impact on Board governance arrangements and a need for Boards to re-consider "governance lite" as had been introduced earlier in the life of the pandemic. He would ensure that the Board were kept advised of any potential impact in this regard.

He confirmed that TSH had received formal confirmation from the Director of Mental Health, Ms Donna Bell, that the updated Remobilisation Plan for the final two quarters of the current financial year was approved and could be published. This was now accessible on the TSH website. Work was being progressed on the next three yearly cycle of future planning for operational intent, workforce and financial planning with formal submission of plans now expected to be due to Scottish Government in July 2022.

Mr Jenkins advised that he had attended the Patient Partnership Group (PPG) on 1 December, meeting patient representatives from each ward and hear their feedback. It had been a wide-ranging meeting including discussion on the continuing impact of Covid-19, staffing capacity as well as the new clinical model. Mr Jenkins confirmed that he was committed to meeting regularly with the PPG as an important means through which he could listen to and engage with patients directly.

Unfortunately, the planned Development Day with Joint Staff Side colleagues had necessarily had to be postponed. It had been planned to take place in person (off-site) and the Covid-19 situation as well as staffing capacity challenges had meant that it had not been possible to support the event at this time. Mr Jenkins stressed that it was of great importance and would be prioritised to take place as soon as possible.

Mr Jenkins advised that the Mental Welfare Commission had conducted a routine visit during November 2021, and that their report was now awaited.

He confirmed that the Short Life Working Group (SLWG) relating to the review of forensic mental health in Scotland had also met, though it may be the case that this work would be delayed due to the current challenges across NHS Scotland. He would keep the Board advised in this respect.

Interviews had been held for the Director of Nursing and Operations post, but it had not been possible to make an appointment and therefore further advice would follow in this regard.

Following this update, Mr Moore underlined the need to keep governance arrangements under review, going into 2022. To date the Board had been successful in retaining its usual governance arrangements and the intention would be to continue to do so, unless this became critical and if so, this would be raised with the Board.

Mr McConnell asked whether a re-arranged date had been confirmed for the Ministerial Annual Review, and Ms Smith confirmed that this was expected in March 2022.

The Board:

1. Noted the update from the Chief Executive.

7a COVID 19 RESPONSE - RESILIENCE REPORTING

A paper was received from the Chief Executive (Paper No. 21/90) to provide the Board with a detailed summary overview of the key factors in the response to Covid-19 since the date of its last meeting.

Mr Jenkins introduced the report by emphasising that the risk assessment for the impact of Covid-19 on TSH had been re-assessed and rated to now be very high. A Level 2 Incident Command structure had been stood up as of 9 December, and its terms of reference were specific in leading the operational response to the impact of the Omicron variant, staffing capacity, as well as any impacts on care delivery presented by the security project works on site. This was being kept under close review, and may require to be escalated to a full Level 3 response structure and the standing down of business as usual workstreams.

Mr Jenkins confirmed that Incident Command had this week agreed to move to a household (6 plus 6) model within hubs and wards for an initial three-week period, and that the Interim Clinical and Support Service Policy, would be kept under review by Incident Command. This was as a precautionary measure and based on best practice on infection prevention and control, based on advice from the Incident Management Team (IMT) set up to manage formal outbreaks of infection within the hospital. There had been two such outbreaks during November, which were now closed, and a further small outbreak currently open and being managed by the IMT.

Mr Jenkins provided the updated position on the programmes for Covid-19 vaccination and Professor Thomson added advice from two studies published this week (from Scotland and South Africa) on the risk presented by the Omicron variant within the context of Scotland having had a successful booster delivery programme and a highly vaccinated population as a result. The third dose of the vaccine (the “booster”) appeared to be critical meaning that the potential for severe illness may be much reduced. Within TSH, 80% of patients had already received this booster, and all patients were being encouraged to take up the offer of vaccination if they had not already done so or upon admission.

Mr Jenkins acknowledged that staff reporting of Lateral Flow Testing (LFTs) continued to be low, but that procurement was reporting that staff were increasingly taking up the offer of these test kits, especially with the national recommendation for daily testing.

With respect to patient flow, Mr Jenkins asked the Board to note the significant drop experienced in patient numbers in recent weeks; and the work being coordinated with medium and low security providers. It was hoped that this position would be continue to be maintained in the future.

Patient visiting was being supported in line with national guidance. In person visiting was for the most part taking place within the Family Centre, taking a risk informed approach to reduce the potential of spread of infection. Limited visiting was taking place within ward areas, and this was dependent on the individual clinical status of patients. In November, the Corporate Management Team (CMT) had reviewed in detail a proposal to develop the visiting model so that most visiting could take place within the Family Centre in the future. This would require some structural changes to implement the model in the long term, and an implementation planning group had been commissioned to take this forward in early 2022. He noted the work being progressed to ensure that an optimal experience could be provided to visitors for digital visiting, with an update to be provided to the next meeting of the Board.

Mr Jenkins summarised the section of the report relating to workforce noting that Incident Command were leading work on contingency planning around the potential for extreme loss of staff, and the need to support the delivery of essential services in this situation. He also outlined the work being progressed on recruitment and the continuing importance of supporting staff with lots of initiatives

and activity led through the Wellbeing workstream. There had been a slight fall in Personal Development Planning and Review compliance levels in the previous two months, related to staff absence and capacity challenges.

Mr Moore thanked Mr Jenkins for this helpful summary and for updating advice of events since the date of reporting. Mr Currie referred to the difficulty of not having confirmation of staff vaccinations (if received in the community) and the experience within social care with families raising concerns about lack of knowledge of individual staff vaccination status. He also asked if embedding digital visiting had brought perceived improvements for both patients and staff groups. He was pleased to see the way that staff wellbeing was at the core of service delivery. Mr Jenkins very much agreed, and advised that that staff wellbeing initiatives would continue to be strongly supported. Further, he noted the difficulty around personal health information for staff as highlighted. In respect of digital visiting, he underlined that this would continue as part of the overall visiting model, and had brought benefits when visiting was not otherwise possible. It was an important service for TSH, as a national board providing services to both Scotland and Northern Ireland, offering visiting when travel was not possible.

Mr Moore asked for clarification on developing a waiting list for admission – Mr Jenkins advised that this was considered as part of contingency planning when patient numbers had increased, but had not been taken forward given the subsequent decrease in patient numbers.

Mr Moore summarised on behalf of the Board, endorsing its recommendations. He emphasised that The Board would like to acknowledge the exceptional efforts made by staff and volunteers to respond to the constantly changing demands of this public health crisis. He noted that the organisational response had been exceptional led by the executive team and all of their directorate teams.

He added that staff wellbeing and patient care and safety were core components for this Board, which did not have comparable options to that of other patient facing NHS Boards of suspending services. On behalf of the Board, he recorded thanks to all involved.

The Board:

1. Discussed and endorsed 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.

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

A paper was received from the Finance and eHealth Director (Paper No. 21/90) to provide the Board with an update on reporting of specific Covid-19 related costs to Scottish Government.

Mr McNaught confirmed that funding support for the full year had been agreed following forecast reporting submitted to Scottish Government for the last two quarters of the financial year, as well as that there would be opportunity for revision should there be variation. It was not anticipated that there would be any material variance for TSH, although there would be potential for this to be taken into the following year. Regular contact was being maintained with Scottish Government to support detailed ongoing review. The budget for 2022/23 was being drafted on the assumption that Covid-19 related costs for would continue into next year, at least Quarters 1 and 2.

In response to a query from Mr Currie relating to recurring costs and transition to the next financial year, Mr Mc Naught confirmed agreement that there would continue to be unknowns and that therefore it was important to maintain dialogue with Scottish Government and to continue detailed review.

The Board:

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

Government.

8 PATIENT, CARER, VOLUNTEER STORY: WHAT MATTERS TO YOU?

Mr Richards introduced this item which was a presentation relating to the experience of volunteers within the hospital, and how this was highlighted through the "What Matters To You?" workstream. Ms Dickson joined the meeting and set this presentation in the context of the many posters created by patients, staff and volunteers, and the work progressed to create jigsaws from these to be mounted within the hospital to help record the hospital's experience of the Covid-19 pandemic.

From a volunteer perspective, she related the experience of one volunteer who had described the difficulty of not being able to visit the hospital in the early months of the pandemic due to restrictions. This had been a personal struggle as he felt that his role as a volunteer added both purpose and structure to each week, and he missed this contact himself as well as realising that patients would also be missing this contact. More widely, the volunteer cohort had asked what they could do if not able to visit patients, and how they could help to support patient activity. They felt that this would be of mutual benefit to patients as well as to themselves.

Ms Fallon asked if direct feedback from patients, carers and volunteers could be presented to the Board at first hand. Ms Dickson confirmed that stories and feedback had previously been presented in this way, and the Board asked that this could be supported again as soon as possible within the context of present challenges. Mr Moore noted the communications strategy which included video clips as a means of sharing stories in a different way.

Action – Mr Richards

The Chair thanked Mr Richards and the Person Centred Improvement Service for continuing to present patient, carer and volunteer stories to the Board as an important means through which the Board could reflect upon the views of stakeholders.

The Board:

1. Noted the content of this presentation
2. Confirmed agreement that stories should return to be presented at first hand (subject to restrictions).

9 PERSON CENTRED IMPROVEMENT REPORT

A paper was received from the Director of Nursing, AHPs and Operations (Paper No. 21/74) which provided the Board with an update on the activities of the Person Centred Improvement Service from November 2020 to October 2021. Mr Richards introduced this report for the Board underlining the depth and breadth of the work progressed. Ms Dickson provided a summary of reporting, highlighting the key pieces of work for the service including the visiting workstream and review of the model, publication of the TSH Equality Outcomes, supporting the Patient Partnership Group (PPG), reinstatement of pastoral care for patients, and the "What Matters To You?" workstream as discussed in the previous presentation.

She also asked the Board to note some key pieces of future planned work including a local volunteer driving scheme. Ms Fallon commented that this would be beneficial and that it would be helpful to see how this impacted positively on patients to support visiting opportunities. She also asked if it would be possible to receive a copy of the TSH British Sign Language Action Plan, and Ms Dickson confirmed that she would do so.

Action – Ms Dickson

Ms Fallon also asked about the possible impact of availability EQIA training may have on the implementation of the new clinical model. Ms Dickson noted that patients have individualised, tailored care plans which would be used for planning of patient groupings.

Mr Moore asked if a Carers Policy was already in existence or if this would represent a new policy for the organisation. Ms Dickson acknowledged that this would be a new policy which would need to be developed. As part of the discussion it was also noted that planning was in place for Non-Executive Directors to take part in Leadership Walkrounds as well as PPG meetings in 2022.

Mr Moore summed up the position of the Board as noting the content of the report, as well as the need for planning around resilience for the service in the future especially for succession planning. A further update in this respect should be brought back to the Board for assurance.

Action – Mr Richards

The Board:

1. Noted the content of this report.
2. Requested an update on resilience of the service and succession planning.

10 PATIENT ADVOCACY SERVICE REPORT

The Director of Nursing, AHPs and Operations introduced a 12 Monthly Report (Paper No. 21/93) from the Patient Advocacy Service (PAS) to provide the Board with a summary of their activities during the period August 2020 and July 2021, in accordance with their Service Level Agreement. The Chair noted that both he and Mr Walker had attended the PAS Annual General Meeting in November.

Ms Carr and Mr Timmons joined the meeting to present their report. Mr Timmons led the Board through a detailed overview, and highlighted the way in which PAS has flexed service delivery during this period in order to meet the needs of patients whilst operating within the constraints brought by the pandemic. He underlined the training and education provision for PAS staff during this period, as well as strengthened leadership through Ms Carr. The majority of key performance Indicators had been met successfully, save for ward drop ins which had been curtailed due to infection control restrictions. At the same time, patient feedback had been that they valued the support provided by PAS, especially during the anxious and difficulties times due to impacts of Covid-19. He asked the Board to note the additional resilience in staffing within PAS to meet these challenges, with recruitment to substantive posts. The PAS Board had also recruited two new Non-Executive Directors within this period, and had also supported a new patient representative to the Board. Ms Carr then added some additional detail around operational delivery of the service within TSH, underlining the increased activity of PAS representatives in supporting patients through a range of ways including supporting through the Care Programme Approach (CPA), Mental Health Tribunals, legal activity and progressing complaints to a successful conclusion.

Mr Moore thanked Mr Timmons and Ms Carr for their very helpful presentation, and commented on the importance of this report for TSH. Mr Richards echoed this underlining the positive relationship between TSH and PAS, which supported a good balance of collaborative working whilst at the same time recognising the independence of PAS; and this could be seen particularly through working relationships with the Person Centred Improvement Service as well as the Complaints Service.

In response to a query from Mr McConnell on recruitment, Ms Carr confirmed that a full-time advocate had been recruited during the year and that the intention was to seek internal applicant for the post of senior advocate/volunteer coordinator as soon as possible, as it was a highly specialised role.

Ms Fallon asked about any risk to information stored in a cloud based system, and was assured that this had been assessed appropriately through the TSH eHealth team. She also asked about the work of PAS to support patients requesting a change in their clinical team. Ms Carr clarified that this may be a request to change Responsible Medical Officer (RMO) or Key Worker and that these requests had increased overall although there was no clear pattern, and PAS would note this as an

area to keep under review in the current period.

Ms Fallon suggested that an introduction to PAS should be added to the Non-Executive Board Member induction programme, and this was agreed as a helpful addition.

Action – Ms Smith

Mr Moore summed up for the Board, and acknowledged the detail contained in the report which showed the quality of service provided by PAS. The Board wished to note the important role played by PAS in the hospital to support patients through a wide range of activities.

The Board:

1. Noted the content of the PAS 12 Monthly Report, and acknowledged the benefit of this independent advocacy service for patients.
2. Agreed that an introduction to PAS should be added to the Board Member Induction Programme.

11 QUALITY ASSURANCE AND QUALITY IMPROVEMENT

A paper was received from the Medical Director (Paper No. 21/94) to provide the Board with an update on the progress made towards quality assurance and improvement activities since the last Board meeting in October 2021.

Ms Merson provided the Board with a summary of the key highlights from the report, focused on Quality Assurance through progress of clinical audits, especially improvements demonstrated in record keeping, and the quality of data provided to the Operational Model Monitoring Group (OMMG).

She also provided an update on Quality Improvement activity through the QI Forum, as well as progress made in the Realistic Medicine workstream with the appointment of a project manager. Finally, she confirmed that work continued to be taken forward relating to Evidence for Quality with 22 reviews completed in this period.

Ms Radage commented on the improvements shown in record keeping as a very positive and speedy piece of work taken forward since the last Board meeting. Mr Richards added that this was excellent progress and showed staff taking ownership for quality improvement and assurance, and driving forward good practice.

Mr Moore asked for further detail around clinical auditing of observation levels, and use of seclusion; and Ms Merson confirmed that there had been significant work progressed in this regard, although acknowledging that it remained an area for improvement. The Clinical Quality Department had set up dedicated contacts for each hub to help support consistency of advice and support to deliver further improvement work. Mr Richards also advised that restrictions under Covid-19 had meant that practical engagement had been more difficult to progress, and that work would be taken forward on observation policy and practice in 2022 in line with national guidance. The seclusion policy was linked to this, and the present policy and practice did not present any concerns in respect of restrictive practice.

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

The Board:

1. Noted the content the report and the range of work described.

12 CLINICAL GOVERNANCE COMMITTEE

The Board received the approved minutes of the meetings of the Clinical Governance Committee that took place on 12 August (CGC(M)21/03).

As chair of the Clinical Governance Committee, Ms Fallon also provided a verbal update on the most recent meeting had taken place on 11 November 2021. This meeting had included a number of annual and quarterly reporting including from the Physical Health Steering Group, Rehabilitation and learning from Feedback and Complaints, as well as child and adult protection. The committee had agreed to re-commence its discussion item in February 2022, if possible. The approved minutes would be provided to the next meeting of the Board in February 2022.

The Board:

1. Noted the approved minutes of the Clinical Governance Committee from 12 august, and the update from the meeting on 11 November 2021.

13 CLINICAL FORUM

The Board received the agreed minutes (CF(M) 21/05) of the meeting of the TSH Clinical Forum which took place on 28 September 2021, and noted the content contained therein.

The Board:

1. Noted the minutes of the meeting of the Clinical Forum which took place on 28 September 2021.

14 ACHIEVING SAFE STAFFING

The Board received a paper from the Director of Nursing, AHPs and Operations (Paper No. 21/96) outlining the position on achieving safe staffing which was currently rated as a corporate risk. This report was submitted to the Board to outline the current challenges and risk level, as well as the actions taken to mitigate this risk. He noted that this issue had already been aired for discussion during this meeting given the importance of it and impacts on service delivery currently being experienced. He led the Board through the report, particularly the “Safe to Start” framework and the focus on recruitment to nursing given the pressures arising in terms of vacancies and upcoming retirements from the workforce.

Mr Richards outlined the interim measures taken to vary deployment of staff across the hospital to support care delivery, and oversight of this through Incident Command. Further that there had been agreement in partnership to progress a supplementary staffing bank and that an implementation group had been commissioned to take this forward.

The Board welcomed this report as being useful, and should return as a regular update. Ms Radage commented on the different landscape for recruitment now being experienced more generally, and that the actions outlined were sensible especially the work progressing on a supplementary staffing bank. She asked about the sickness absence target rate (at not exceeding 5%) in terms of whether it was realistic. Mr Jenkins noted that this figure may be more relevant in times of usual business, rather than the present period of extreme pressure. Incident Command would consider the staffing capacity overall in relation to safe delivery of care. It was agreed that Mr Richards would share the “Safe to Start” framework with Non-Executive Directors, to further assist understanding of the position.

Action – Mr Richards

In response to a question from Mr McConnell on how the proposed bank would operate, Mr Richards advised that this was focused on available internal staffing resources – staff in other departments who

may be willing to join a bank e.g. housekeeping or security staff, as well as students on placements. This work would be managed carefully in terms of the size of the bank, and would take as improvement based approach. He added that it was important to recall that all other patient facing NHS Boards operated a staff bank as a mean of providing supplementary staffing.

There was further discussion on this, which noted the risk of a staff bank if there was opportunity to staff to enrol on that rather than considering taking a permanent role. It was highlighted that TSH differed from other patient facing NHS Boards in not being able to stand down key functions at times of extreme pressure. Mr Richards underlined that the approach taken here was flexible and that presently the offer was to internal staff only and would not impact their substantive roles. For students, this may be a welcome opportunity for them to develop skills for their career progression and may encourage then to consider a permanent role at TSH in the future.

Mr Jenkins commented that work in relation to supplementary staffing was hugely important, and the extent of this task should not be underestimated, and thanked Mr Connor and partnership colleagues for their constructive input in this regard. He added that the standing down of patient activity was a grave concern, and Professor Thomson added that impacts on patients were being carefully monitored. It was imperative to take into account these impacts with patients becoming weary of the present constraints on services.

Mr Moore summarised the discussion for the Board, acknowledging the intense activity ongoing and adding that the Board should be kept updated on key issues. It was noted that staff bulletins would continue to be produced following incident command meetings, and that any additional briefings would be routed to Non-Executive Director from the Chief Executive if required.

The Board:

1. Noted the content of the report, and work progressed as described therein.
2. Requested further regular updates through Board meetings, and interim briefings if required on any significant issues or risk to the Board.

15 ATTENDANCE PERFORMANCE REPORT

The Board received a paper from the Director of Workforce (Paper No. 21/97) which summarised the position on staff attendance for the most recently reported period to 31 October 2021.

Ms Davidson provided an overview of the detail, including sickness absence as well as absence due to Covid-19. She added that Human Resources were linking with line managers to ensure that staff were receiving support during absence to help them to return to work, and that a further update would be provided at the next Board meeting.

The Board noted the content of this update report.

The Board:

1. Noted the content of the Attendance Performance Report.

16 WHISTLEBLOWING REPORTING

The Board received a paper from the Director of Workforce (Paper No. 21/98) which provided an overview of activity within TSH related to the NHS Scotland Whistleblowing Policy, as well as a paper from the Board Secretary (Paper No. 21/99) detailing a draft response to the Cabinet Secretary for Health and Social Care in this respect.

Ms Davidson confirmed that there were currently two cases being considered under the policy, one of which had been concluded locally, but could be referred to the Independent National Whistleblowing

Office as a final stage on the process. The second case had recently been received and was being investigated under stage 2 of the policy process.

Ms Smith noted that the Cabinet Secretary had requested an update from each NHS Board's Whistleblowing Champion. This was currently a vacancy position within the Board, with recruitment expected to be taken forward through Public Appointments shortly. Therefore, the Board Chair had prepared a response covering his period of office as Whistleblowing Champion. Ms Smith detailed that the response confirmed that appropriate governance arrangements were in place. Further, she noted that communications had been circulated to staff that advice on whistleblowing could be sought through any Non-Executive Director, given the current vacancy for this post.

It was agreed that this response should be updated to reflect receipt of a new case, and submitted.

Action – Ms Smith

The Board:

1. Noted the content of the two whistleblowing updates.
2. Agreed that, subject to minor amendment, the response to the Cabinet Secretary for Health and Social Care should be submitted, subject to minor amendment.

17 STAFF GOVERNANCE COMMITTEE

The Board received the approved minutes of the meetings of the Staff Governance Committee that took place on 19 August 2021 (SGC(M)21/03).

As chair of the Staff Governance Committee, Ms Radage also provided a verbal update on the most recent meeting of the committee on 18 November 2021, which had reviewed Occupational Health, staff wellbeing, Healthy Working Lives as well as iMatter reporting.

The Board:

Noted the approved minutes of the Staff Governance Committee from 19 August, and the update from the meeting on 18 November 2021

18 FINANCE REPORT – TO NOVEMBER 2021

A paper was submitted to the Board (Paper No. 21/100) by the Finance and eHealth Director, which presented the financial position to 30 November 2021.

Mr McNaught led Members through the report, advising the small underspend position of £234k, and that year end forecasting was for a breakeven position. As previously discussed costs not named within the current year would be tracked into the 2022/23 draft budget. In terms of capital, he advised that as spend was not spread evenly throughout the year, reporting reflected funding received as matched to spend to date and that a breakeven position was anticipated for year-end.

The Board was content to note this update report.

The Board:

1. Noted the content of the Finance Report to Month 8.

19 PERIMETER SECURITY AND ENHANCED INTERNAL SECURITY SYSTEMS PROJECT

A report was received from the Director of Security, Resilience and Estates (Paper No. 21/101) which provided an update in relation to the Perimeter Security and Enhanced Internal Security Systems

Project.

Mr Walker asked the Board to note in particular the response to Scottish Government: Construction Policy Note CPN 4/2021. He also advised that the expected completion date for the project was now late May 2022. He noted that the Project Oversight Board meeting scheduled for 16 December had been re-scheduled to January 2022.

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

The Board:

1. Noted the content of this report.

20 PERFORMANCE REPORT QUARTER 2 – 2021/22

A paper was submitted to the Board (Paper No. 21/102) by the Head of Corporate Planning and Business Support, which provided a high level summary of organisational performance through the reporting of Key Performance Indicators (KPIs) for Quarter 2 of the current financial year.

Ms Merson asked the Board to note in particular that eight KPIs had been reached or exceeded, and that four had not been met. She described these four KPIs in further detail, with the background on the challenges in each respect. The Board noted the work progressed in respect of the KPI relating to the offer of an annual physical health review which was helpful.

The Board was content to note this report.

The Board:

1. Noted the content of this report.

21 EHEALTH REPORTING: ANNUAL REPORT 2020/21 & DIGITAL INCLUSION UPDATE

A paper was submitted to the Board (Paper No. 21/103) by the Finance and eHealth Director, which presented an overview of activity within eHealth during 2021/22, as well as an update on work progressed on the digital agenda more recently. Mr McNaught introduced this paper as a comprehensive summary for the Board giving an insight into the breadth and scale of the work the department undertakes. He also highlighted that the eHealth team had won an award at the recent Staff Excellence Awards event, which was in special recognition of the contribution made by the team.

Mr Best joined the meeting, and summarised reporting for the Board, highlighting the key achievements delivered by the eHealth team. This included the progress made in particular to urgently step up a framework for remote working for staff able to work from home, due to the onset of the pandemic. Further, the RiO upgrade project which presented a considerable undertaking and was progressing well. The team had supported the roll out of windows 10 across the organisation as well as the implementation of Microsoft 365, in line with the national agenda. A further major focus was the digital inclusion agenda for patients, especially given the challenges of this within a high secure setting.

He also described ongoing project work and future plans for the team, including Disaster Recovery test plans and supporting the implementation of HEPMA (the electronic prescribing system).

Mr Moore thanked Mr Best for the report and the excellent work of the team, who had made a significant contribution to service delivery within the hospital during this period. This was very much

echoed in discussion round the table, and the report was received very warmly. In response to a query from Ms Fallon on the implementation of SharePoint and preparation for this to help support staff, Mr Best confirmed that work had begun through Records Management to review data held locally by teams, and how to better manage this as this would be helpful before SharePoint was rolled out. There was discussion around staff delivering patient facing services and how best to support them, and Mr Best confirmed that this would be part of the remit of the Microsoft 365 Project Team in terms of how to offer guidance and support. He acknowledged that this would be a considerable piece of work. Mr Jenkins added that this would be considered further through the CMT, and led by Mr McNaught.

Mr Moore summed up this discussion for the Board, formally noting thanks to the eHealth team for their tremendous achievement and contribution made.

The Board:

1. Noted the content of this report.
2. Acknowledged and thanked the eHealth team for the success of the work delivered and contribution made.

22 INFORMATION GOVERNANCE – ANNUAL REPORT 2020/21

A paper was submitted to the Board (Paper No. 21/104) by the Finance and eHealth Director, which presented an overview of the work carried out within Information Governance. Mr McNaught introduced this report a representing the extensive work taken forward in this regards. Mr Lawton joined the meeting and highlighted some of the key areas of reporting for the Board. This included the work taken forward in Records Management, and the TSH Information Asset Register, a programme and record of destruction of records, as well as the provision of guidance and training on information governance standards and risk assessment across the organisation. He also acknowledged some areas which had been impacted by the Covid-19 pandemic, most notably information governance walkrounds as well as response times for subject access and freedom of information requests.

The Board received this report positively, and Mr Moore thanked Mr Lawton on their behalf. It was noted in particular that work was progressing in records management for the appropriate retention and destruction of records.

The Board:

3. Noted the content of this report.

23 COMMUNCIATIONS ANNUAL REPORT – 2020/21

A paper was submitted to the Board (Paper No. 21/105) by the Head of Communications, which provided a summary of activity during 202/21. Ms McCarron led the Board through the key areas of the report which included updates on communications as well as engagement activity undertaken through the Person Centred Improvement Service.

Ms McCarron highlighted that there had been a need to respond quickly to the Covid-19 pandemic, and that it was clear that the production of internal communications to staff through an increase circulation of bulletins had been essential. Further, that during this period, core communication tasks had also been completed. She went on to say that future planning would include a review of the communications resource to ensure an effective service going forward.

Ms Radage commented that effective communication was hugely important and would reflect well on the organisation. Mr Jenkins added his thanks for the work undertaken throughout this period.

Mr Moore summed up that this report contained a wealth of information, and the work progressed was acknowledged by the Board.

The Board:

1. Noted the content of this report.

24 CORPORATE GOVERNANCE IMPROVEMENT PLAN

A paper was received (Paper No. 21/106) from the Board Secretary to outline continuing progress and actions taken as part of this plan. Ms Smith highlighted four key areas including effective rostering (and detailed updates had been provided by the Director of Nursing, AHPs and Operation) and the commucnaitions strategy (as updated by the Head of Communications).

She also asked the Board to note the Active Governance session scheduled to be delivered on 13 January 2022, subject to any constraints through Covid-19, and the work progressed on visibility of Non-Executive Directors particularly through a scheduled programme of Leadership Walkrounds and attendance at Patient Partnership group meetings.

The Board were content to note this report.

The Board:

1. Noted the update presented in this report.

25 BOARD WORKPLAN 2022

A paper was received (Paper No. 21/107) from the Board secretary to propose a workplan for the Board for the coming year. Ms Smith presented this report, highlighting the key areas of focus. She acknowledged that the ongoing pandemic may cause there to be some alteration to the workplan throughout this period of working, and that the plan had been adjusted to reflect this across all aspects of strategic planning and operational delivery.

She asked the Board to consider the reporting plan to give assurance on the delivery of key workstreams, particularly the new clinical model and the Supporting Healthy Choices programme. Further that service planning reports for future operational planning as well as financial governance and workforce planning were included in accordance with the national guidance and timings as currently set out.

Ms Smith noted that the schedule of annual reporting had been refreshed to being reporting to the Board earlier in the yearly cycle, especially around Risk and Resilience and eHealth. Additional reporting had been added for the Board's response to sustainability in the context of the climate emergency, in line with national guidance.

The Board considered the plan as presented, and agreed that it did provide a suitably structured framework for assurance reporting, as well as the flexibility required should change be required throughout the course of this period.

Mr Moore thanked Ms Smith for preparation of the plan and confirmed that the Board were content to accept this framework as appropriate for scrutiny of the Board's business during 2022.

The Board:

1. Reviewed the revised workplan and approved it as the basis for managing Board Business in 2022.
2. Noted the potential for changes to the plan subject to the impact of Covid-19

26 CORPORATE RISK REGISTER

The Board received a paper (Paper No. 21/108) from the Director of Security, Resilience and Estates, which provided an overview of the medium, high and very high risks featuring on the Corporate Risk Register, and provided assurance that these were being addressed appropriately.

Mr Walker presented this report and highlighted the refreshed format of it, asking for views on this.

He confirmed that the two risk reviews outstanding had been progressed and updated since the date of reporting. He also asked the Board to note in particular that Risk CE14 (relating to impacts on service delivery through Covid-19) had been assessed through the CMT as being very high due to the Omicron variant; and that risk SD53 (relating to security works) had been assessed as temporarily being high due to the use of "At Height" vehicles on site as part of the security upgrade project, with suitable mitigations in place in response to this.

He also underlined the ongoing focus within the Risk Team to support the relevant risk owners to track and review risks which had not met their target risk grading.

The report was received positively by the Board in terms of its content and refreshed format. Mr Currie asked for further input on how risks were being tracked, and Mr Walker confirmed the governance arrangements in place to oversee this, headed by the CMT which received fortnightly updates, alongside the support provided through the Risk Team to risk owners.

Mr Moore thanked Mr Walker for reporting, and confirmed that the new format was helpful. He noted the Board's agreement that no further amendment was required to the register.

The Board:

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

23 ANY OTHER BUSINESS

No other business was raised.

24 DATE AND TIME OF NEXT MEETING

The next meeting would take place on Thursday 24 February 2022, by way of MS Teams.

The meeting ended at 1330 hours.

ADOPTED BY THE BOARD

CHAIR _____

(Signed Mr Brian Moore)

DATE _____

THE STATE HOSPITALS BOARD FOR SCOTLAND
ROLLING ACTION LIST

ACTION NO	MEETING DATE	ITEM	ACTION POINT	LEAD	TIMESCALE	STATUS
1	February 2021/April 2021	Resilience Report – Covid-19 (Item 7a)	Provide benchmarking comparison to other organisations on use of virtual visiting	R McNaught/ D Walker	Re – adjusted to February 2022	August: Update included in Covid response report at Item 7a. Full report to be brought to October meeting Update: trial of new system used in other high secure hospitals pending start date = delayed due to need for full DPIA to be completed. Update to Board in December. **Update – Work progressing to pilot following completion of DPIA- further report following pilot.**
2	August 2021	Covid Resilience Report (Item 7a)	To progress work on link between performance metrics and the governance structure e.g. how do individual metrics get tracked.	M Merson/ M Smith	Re-adjusted to February 2022	Work in progress as part of performance metrics / active governance and update to be brought back to board. **Active Governance session scheduled for Jan 2022 postponed by agreement, and date offered for May session.**

3	August 2021	Corporate Risk Register(Item 22)	To review the oversight committee for each risk –clarify executive /board oversight.	D Walker	December 2021	On October Agenda as part of reporting. Report reviewed and suggestions made, new format of reporting is included in December meeting. **Update December Refreshed report format presented, and agreed. CLOSED**
4	October 2021	Covid Resilience Report (Item 7a)	Provide update on digital inclusion/care	R McNaught	December 2021	On Agenda as part of eHealth Annual reporting. **Update – December full review and update presented as part of reporting – on workplan for 2022. CLOSED**
5	October 2021	QA and QI (Item 12)	Request that trend reporting on clinical audits be included in future reporting.	M Merson	February 2022	**Reviewed as part of reporting in QA and QI/ clinical model board reports. CLOSED**
6	December 2021	Patient, Carer Volunteer Story (Item 8)	Request that stories return to being presented first hand, using digital means if possible, as soon as service delivery allows.	M Richards	April 2022	**The use of 'digital touchpoints' will be a feature of the presentation the April Board.**
7	December 2021	PCIS Report (Item 9)	Request to send BSL Action Plan to non exec (CF)	M Richards	Immediate	**Has been completed CLOSED**

8	December 2021	PCIS Report (Item 9)	Request for update back to Board on succession planning for the service.	M Richards	February 2022	**To ensure service capacity and leadership resilience, a new Charge Nurse is being created for the PCIS. This will be advertised in February 2022.**
9	December 2021	Patient Advocacy Service Report (Item 10)	Request to add introductions to PAS to Non Exec Induction	M Smith	Immediate	**Has been added and link made to PAS on best means to do so for next induction CLOSED**
10	December 2021	Achieving Safe Staffing (Item 14)	Request to circulate framework to non execs	M Richards	Immediate	**Has been completed CLOSED**
11	December 2021	Whistleblowing Reporting (Item 16)	To make minor amendment to letter to Cab Sec and submit	M Smith	Immediate	**Has been completed CLOSED**

Last updated – 14.02.22 – M Smith

Author:
Margaret Smith
Board Secretary
01555 842012

Paper No. 22/02

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	24 February 2022
Agenda Reference:	Item No: 7a
Sponsoring Director:	Chief Executive
Author(s):	Board Secretary
Title of Report:	TSH Response to Covid 19 Global Pandemic – Update
Purpose of Report:	For Decision

1 SITUATION

The Board receives an update report at each of its meetings in respect of the continuing response to the global Covid-19 pandemic by The State Hospital (TSH). This is in the context of NHS Scotland remaining on an emergency footing until at least 31 March 2022, and TSH is following Scottish Government guidance in relation to any requirement for restrictions within the health and care setting.

The Corporate Risk Register will be presented to the Board today, and the Risk for Covid-19 remains as Very High. Mitigation to this risk continues to be managed through prioritisation of strategies to protect the health and wellbeing of both patients and staff, and to minimise as far as possible the risk of transmission of the virus through staff and patient populations

2 BACKGROUND

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

2.1 Board Governance

Throughout the Covid pandemic The State Hospitals Board for Scotland has been able to maintain all aspects of board governance, including its regular schedule of Board and Committee meetings. However, systems pressures during December 2021 and January 2022 were considered to present considerable risk to operational resilience, particularly in relation to staffing capacity.

For this reason, the Board reviewed its ability to proceed effectively with the Audit Committee which had been scheduled to take place on 27 January 2022. This took into account meetings of the other standing committees scheduled in February as well as review of the agenda items for the Audit Committee, confirming that there would be no detriment to a short postponement.

A decision followed to re-schedule this meeting, amalgamating the business at hand with the next meeting due to take place on 17 March 2022.

2.2 Senior Leadership and Management Structure

At its last meeting on 23 December 2021, the Board was advised that Level 2 Incident Command Structure was stood up on 9 December, led by the Chief Executive in view of the global developments around the Omicron variant, and the impacts this may have on service delivery for TSH. Incident Command (Level 2) led decision-making in respect of the following in terms of service delivery:

- Impacts of Omicron variant on Covid-19 risk
- Impacts of staffing capacity
- Impacts of security project works.

This was subsequently escalated to Level 3 Incident Command, as of 10 January 2022:

Level 3 – *Those incidents which require the setting up of a full Incident Command structure which will require additional resources and back up services to be deployed.*

This was in view of increased risk presented by the Omicron variant of Covid19 for the delivery of services with the expectation that would remain the situation during January 2022.

Level 3 Incident Command consisted of Gold and Silver Command layers and this structure led all decision-making for the delivery of services at TSH, replacing existing governance structures. Gold Command was chaired by the Chief Executive, and provided leadership on all aspects of governance save for the following exceptions which continued to deliver in areas of high importance for the organisation.

- Clinical Governance Group
- Infection Control Committee
- Security Project Meeting
- Capital Group
- RiO Upgrade (Electronic Patient Record)

Gold Command received regular reporting on national and local surveillance/modelling as well as updates from NHS Lanarkshire's Horizon Scanning Group, and the Lanarkshire Local Resilience Partnership.

Silver Command was co-chaired by the Director of Security, Resilience and Estates and the Director of Nursing, AHPs and Operations. Silver Command led on day to day operational delivery seven days a week overseeing staffing capacity and related risks, and reporting the position to Gold Command.

There was also dedicated focus on supporting the continuation of Clinical Team Meetings and Care Programme Approach patient case reviews.

During January an improving positon gradually emerged, with the numbers of staff impacted by either infection/self-isolation requirement from Covid-19 reducing, and a related improvement the hospital's ability to meet service demands. The position can therefore be summarised as being one of a stabilising landscape within TSH, in alignment with local and national surveillance and modelling. Incident Command was capable of being stood down on 27 January with a return to normal governance arrangements led through the Corporate

Management Team (CMT) Organisational Management Team (OMT) and Hospital Management Team (HMT) and the wider layers of reporting governance groups.

CMT receives the full range of reporting previously received relating to the impacts of Covid-19, including formal assessment of risk, care delivery impacts and surveillance /modelling reporting. This also includes links to includes links to NHS Lanarkshire's Horizon Scanning Group as well as the Lanarkshire Local Resilience Partnership and the national framework for NHS Scotland led by the Cabinet Secretary for Health and Social Care.

In addition, national guidance is reviewed to ensure an appropriate TSH response, and to ensure alignment with NHS Scotland strategy.

It is also recognised that the position may change in the future, and do so quickly, due to the potential of new variants (with potentially unknown characteristics and associated impact on assessment of risk). The Board is offered assurance that should this be the future, TSH is in a position to respond to emerging risk in this structured way through Incident Command.

Dedicated support for the response to Covid-19 is provided through a range of disciplines and departments from infection control, clinical operations, human resources and administrative services. Resourcing to the Corporate Services Team is under active review to ensure that this function is resilient and able to provide the business support required in this changing landscape.

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.

During December and January, the hospital has experienced two small outbreaks of Covid-19 and this required an Incident Management Team to be stood up in support. This is outlined in the following section (at Section 3.3).

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

The Board has been kept advised on decision-making for the delivery of care within TSH through adjustment of the Interim Clinical and Support Services Operational Policy. This has included scrutiny and review of the data gathered by the Clinical Quality team, focused on impacts on patients.

At its meeting on 23 December, the Board received an update outlining the change to a service delivery of the household model 6 + 6 model allowing a cohort of 6 patients up at any one time to ensure safe physical distancing and to minimise risk of viral transmission.

This model was regularly reviewed by Gold Command during January, and it was agreed that this model should stay in place given the benefits of helping to mitigate against the risk of vial transmission given the prevalence of Covid-19 in the wider community, underlined by support for this model by the Incident Management Team (overseeing two small outbreaks within the hospital at this time).

At the end of January, and led by advice from the Infection Control Committee, it was agreed that a cautious and phased approach could be taken to rolling back from the household 6 + 6 model. This was in the context of the wider national changes announced by Scottish Government on 24 January in respect of community mixing, and the downward trend being

evidenced in community infection. The hospital moved to a household model on 31 January, and then to supporting a model of patient mixing as of 10 February. This has brought a marked difference in patient activity, especially programmes supported through the Skye Centre. The model is being kept under review by the Corporate Management Team to ensure continued focused consideration of how best to ensure patient activity is delivered most effectively.

3.2 Infection Control Committee

The Infection Control Committee has continued to meet monthly providing oversight for the management of Covid -19 within TSH. This includes detailed review of National Guidance on infection control requirements for any impact on TSH. During the period of Incident Command, the Infection Control Committee provided detailed advice to Incident Command especially around operational model delivery, and on how best to support visiting in person for patients and carers during this period.

The programme of Covid-19 audit work is continuing as part of the wider programme of infection control audit. Infection Control support continues to be provided to all staff around the importance of following guidance and appropriate use of PPE.

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

3.3 Covid-19 Incidence

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

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

Month	August	Sept	Oct	Nov	Dec	Jan
Total Tests	25	81	62	153	125	64
Asymptomatic tests	2	73	59	149	9	2
Positive results	2	4	3	6	10	4
Negative results	23	77	59	147	115	60

Table 1: Patient Tests and Results August 21 – Feb 2022

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

	Total	Positive results	Negative results	% positive tests (of all tests)	% positive rate (of staff *wte n650*)
September	103	17	86	16.5%	0.03%
October	72	18	54	25%	0.03%
November	77	12	65	15.6%	0.02%
December	140	39	101	27.9%	0.06%
January	114	54	60	52.6%	0.08%

Table 2: Staff PCR testing and results

3.4 Response to Outbreaks

The hospital experienced two outbreaks of Covid-19 in Iona 2/Arran 3 wards and in Lewis 3 ward, with a further singular patient case identified in Lewis 2 ward. These outbreaks were managed through the standing up of an Incident Management Team (IMT) with colleagues from NHS Lanarkshire and the Outbreak Management Team from Scottish Government. The hypothesis reached was that the outbreaks were a consequence of high levels of community based transmission, with subsequent staff to patient transmission.

The actions taken included patient testing and isolation of wards, reinforcement of the message regarding PPE compliance, as well as continuation of the enhanced cleaning measure in place by both housekeeping and ward staff. With the agreement of the IMT, all wards were able to re-open by 10 January 2022.

For Iona 2/Arran 3 wards, there was detailed consideration of the position by the IMT, given that two asymptomatic patients who had previously had covid within 90 days tested positive again, meaning that there could potentially be an extended period of ward closure of up to six weeks. The IMT advised that subject to the patients remaining asymptomatic it was reasonable to end ward isolation on 10 January with the understanding that patients would be nursed following household model of 6+6 and that no admissions were expected.

At the time of reporting, there are no formal outbreaks within the hospital. During the first two weeks of February, three patients appeared symptomatic and were tested, with Iona 1 ward being isolated between 9 to 11 February until testing was confirmed as negative. Similarly, Lewis 1 ward closed on 14 February, re-opening once the patient test result was confirmed as negative.

3.5 Covid-19 Vaccination Programme

TSH has continued to deliver its programme of vaccination as part of the national roll out of the Covid–19 vaccination programme.

At the Board meeting in December, it was confirmed that all eligible staff had been offered two doses of the vaccine, with an uptake of 88%. This was followed by an offer to eligible staff of a booster vaccination with staff vaccination clinics being organised to deliver this during December 2021.

Measurement of the data in regard to patient vaccination changes over time to reflect patient flow through admissions in and transfers out of the hospital. All newly admitted patients continue to be offered vaccination, depending on their individual stage within the vaccination cycle and uptake remains high. At the time of reporting, 99 patients have received all three doses of the vaccine, representing 88% of patients overall. Uptake is monitored and patients are supported and advised on the importance of vaccination.

3.6 Test and Protect

All staff continue to be encouraged to self-test by Lateral Flow Device (LFD) is on a voluntary basis, and to register their test results. However, daily reporting rates are low across NHS Scotland with TSH reporting a 5% on average compared to a national rate of 7% (reported as a percentage of the expected overall number of tests).

All contractors coming on site continue to undertake LFD testing. Auditing of this has continued and no issues have been noted with the uptake and management of this control measure.

3.7 Clinical Care Guidance for COVID-19 patients

The Board has received regular updates on the reviewed contingency planning for the delivery of enhanced care for patients on site for symptoms of Covid-19, in the context of pressures on service delivery in NHS Scotland in the winter period. This has recognised the ongoing developments in medical care for Covid-19 to ensure that planning is in place for appropriate and safe care. This would only be should it not be possible to transfer a patient to acute care. However, NHS Lanarkshire have continued to have capacity for a model of care delivery wherein any TSH patient who requires acute medical care, will be transferred to a general hospital.

3.8 Personal Protective Equipment

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

3.9 Patient Flow

TSH is linked through collaborative work and contingency planning with medium and low security care providers; including admission to and transfer between secure mental health services, suspension of detention and preparation for moving into the community. This continues to be focused on those patients for whom a move to medium secure facilities or those for whom a prison setting would be appropriate. This involves regular transfer review meetings and links with medium secure units, as part of the Forensic Network Capacity Plan.

The following table outlines the high level position from 1 December 2022 to 31 January 2022.

	MMI	**LD**	**Total**
Bed Complement	128	12	140
Staffed Beds	108	12	120
Admissions	2	1	2
Discharges / Transfers	6	0	6
Average Bed Occupancy: Available beds/All beds			92.5% **/** 79.3%

Table 3: Patient flow 1 December 2021 to 31 January 2022

3.10 Virtual and In Person Visiting

In Person Visiting

Following a clinically led review to consider the optimal visiting model, it was agreed to support the continuation of visiting within the Family Centre, to meet the needs of patients and carers

and to respond to the positive feedback on the current model. Key structural works were identified as being required to facilitate this and implementation planning is underway including costing for capital works. A further update will be provided to the Board at its next meeting. In the meantime, the existing model is being supported for visiting in the Family Centre, with ward visits taking place if required (due to individual clinical status of each patient).

Some patients may not have designated visitors, and additional support for these patients is in place through volunteer visitors.

TSH will continue to follow national guidance on hospital visiting, to ensure compliance with infection control guidelines. Visitors are encouraged to undertake Lateral Flow Device (LFD) Testing, on a voluntary basis to help support infection control within the hospital.

Virtual Visiting

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

Development work to review other means of supporting virtual means of visiting including alternative platforms is a key area of focus to help establish the most optimal digital platform for virtual visiting, given positive patient and carer feedback about the availability of this form of contact. A Data Protection Impact Assessment was required to enable a pilot to be taken forward, and this has been finalised. The eHealth team are now able to establish a pilot scheme subject to the information governance guidance provided. The Board will receive regular updates on the progression of this workstream.

3.11 Workforce

3.11.1 Attendance Management

The Board receives dedicated reporting separately in respect of attendance performance, including Covid-19 related absence.

3.11.2 Planning for Extreme Loss of Staff

The Extreme Loss of Staff Plan for TSH, which was developed at the start of the pandemic, in response to a significant threat to business continuity.

Preparation was put in place in case there should be a need to stand up extreme loss of staff contingency planning. The Head of Risk and Resilience took forward a comprehensive planning exercise to refresh and evaluate local data, and provided regular assurance reporting to Gold Command on available staff resourcing which could be sourced in extremis, including a register of volunteers for redeployment to alternative duties.

This did not prove to be required as the situation developed under Incident Command arrangements in December and January; although PMVA Level 2 trained staff were asked to support service delivery through different deployment arrangements. Staff cohorts responded well to this, and this was particularly evidenced through wider clinical teams including Skye Centre staff and Allied Health Professionals.

3.11.3 Staff Recruitment

Human Resources have continued to take forward the recruitment process for all confirmed positions with appointments made across a range of disciplines, with particular focus on the recruitment of registered and non–registered nursing staff.

Overall, there are currently 27 posts actively moving through the recruitment process from the following departments: Nursing, eHealth, Medical, Psychology, housekeeping, catering, Patient Welfare and Finance, estates, HR, Housekeeping, Practice Development and Executive level.

Human Resources are prioritising the on-boarding of new recruits into the organisation, including expediting inductions and training programmes

Nursing recruitment continues to be of particular focus with a clear programme of steps in place to expedite recruitment of both registered and non-registered nurses, students and the use of the retire and return policy. This targeted recruitment plan is continuing successfully, and has decreased the staffing deficit in nursing significantly. The nurse pool adds further resilience through student nurses, non registrants as well as the retire and return policy. This does have an impact on the skills mix within the nursing workforce, and this is recognised in the need work to actively seek registrant nurses. TSH is taking every opportunity to participate in recruitment fayres (the next event opportunity taking place on 22 February) as well as national digital platforms to demonstrate the benefits of a career with TSH.

3.11.4 Staff Wellbeing

The Staff Wellbeing Centre continues to be used as a drop in facility for tea breaks and lunch breaks as well as making use of massage equipment. Volunteers are now using the space every Wednesday for lunch. Managers are being asked to ‘give permission’ to staff to use the space in line with their own service needs.

Wellbeing activity planning is progressing strongly with a range of activities being offered including yoga classes in the Skye Centre commencing in February, as well as relaxation, crochet, knitting, table tennis and craft classes in the Wellbeing Centre. MS Teams will be utilised for Listening and Reading Groups. A virtual walking challenging along the West Highland Way will take place in March, with prizes for best performance.

Mental Health training for Managers will commence in March/April, supporting managers to integrate a consistent approach to mental health and wellbeing. The aim is to roll this training out to all staff throughout 2022.

The £6,000 of Winter Pressures funding received has been well used. Ninja air fryers have been purchased for wards, Security and the Skye Centre. Larger fridges have also been ordered for areas where water coolers are unavailable. In addition, care packages (boxes with tea, coffee, hot chocolate and sweet and savoury snacks) were distributed to all tearooms across the hospital in mid-January. A further £5,000 of Winter Pressures funding has been allocated to TSH to be spent on wellbeing provisions.

The new Healthcare Chaplain/Pastoral Support Worker has commenced employ with NHS Lanarkshire and will begin their role in TSH shortly, once the Service Level Agreement arrangement has been finalised. This will be for 12 months with a 9-month review within that period.

Work has also continued on development of the Wellbeing Strategy, offering opportunities for staff groups to provide feedback. The aim is to present the strategy, including a supporting action plan, to the Board at its next meeting in April 2022.

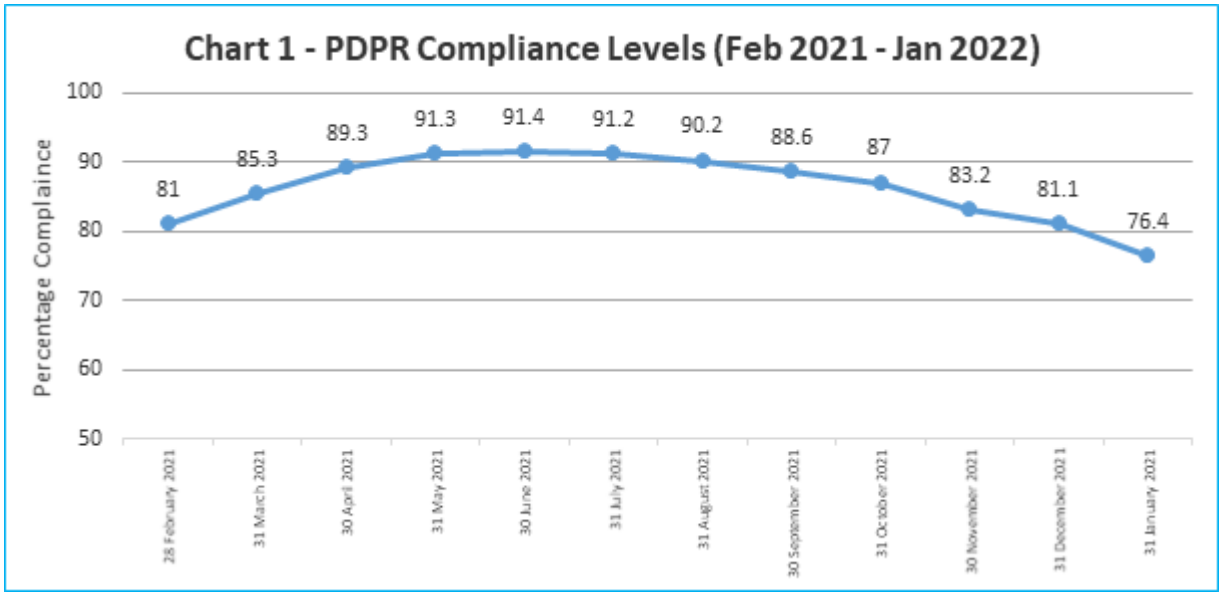
The Healthy Working Lives Group will meet on 24 February to take forward planning for 2022/23 around the activities and campaigns required to achieve and maintain the Healthy Working Lives Gold Award.

3.11.5 Personal Development Planning and Review (PDPR) compliance

As at 31 January 2022:

- The total number of current (i.e. live) reviews was 465 (76.4%).
- A total of 114 staff (18.7%) had an out-of-date PDPR (i.e. the annual review meeting is overdue).
- A further 30 staff (4.9%) had not had a PDPR meeting. Staff in this group are predominantly new staff with an initial set-up review meeting overdue.

Chart 1 shows the trend in organisational PDPR compliance levels for the 12-month period from February 2021 to January 2022.



As indicated in Chart 1, PDPR compliance levels have shown a downward trajectory since July 2021. Staff absence and associated staffing resource pressures have been reported by managers as key contributory factors in the reduction in compliance. This was highlighted to the Corporate Management Team on 16 February, to highlight the need to help support line managers in taking reviews forward.

3.12. Communication

Staff Bulletins have continued to provide communication throughout the organisation, providing high level feedback to staff about national developments, as well as more local updates for TSH. During this period there has been focus on ensuring regular communication to all staff from

Incident Command as well as covering the importance of infection control and prevention measures, as well as the management of the Covid-19 outbreaks within the hospital.

The Wellbeing Team have issued their first dedicated bulletin to make sure staff are aware of all the initiatives and programme available and under development.

3.13 Digital Technology

The Board receives regular updates on the programme of digital transformation for the hospital. The eHealth Team has successfully recruited an eHealth Project Manager for a one-year post to assist with the further development of the electronic patient record (RiO) and patient digital inclusion projects.

The RiO upgrade is progressing well with on-line training now available for staff through LearnPro. The go live date is expected to be 8 March 2022. Locally, work is also progressing on rolling out patient internet browsing devices, with this now pending delivery of suitable furniture for patient areas, and planned implementation for April 2022.

In line with national projects, access is awaited to O365 SharePoint and OneDrive, as well as works progressing on electronic prescribing (HEPMA) with planning to have all the required equipment configured and in place by the end of March, for a go live date in April 2022. This system will be accessible from RiO and will allow patent medication details to be created and accessed electronically.

3.14 Remobilisation Planning

TSH continues to provide quarterly updates to Scottish Government on the TSH Remobilisation Plan for the current year, and work is progressing on the operational plan for 2022/23 within the context of three–year forward look as informed by Scottish Government guidance for the development and cohesion of NHS Board Plans. Planning is in place for this to be submitted towards the end of Quarter 1 in 2022.

In the meantime, it is confirmed that a quarter 3 update was submitted to Scottish Government at the beginning of February to demonstrate progress to date.

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

The Board will receive reporting at this meeting to outline its Corporate Objectives for 2022/23.

4 RECOMMENDATION

The Board is invited to:

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

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

Paper No. 22/02

Author:
Margaret Smith
Board Secretary
01555 842012

MONITORING FORM

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

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	24 February 2022
Agenda Item:	Item No. 7b
Sponsoring Director:	Director of Finance and eHealth
Author(s):	Director of Finance and eHealth
Title of Report:	Financial Governance – Covid-19
Purpose of Report:	For Noting

1 SITUATION

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

2 BACKGROUND

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

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

For 2021/22, on a similar timing basis to 2020/21, reports for Q1-Q3 have been prepared and submitted, incorporating ongoing forecasts of expected costs for the remainder of the financial year. This is on the basis that Covid-related costs, while initially expected to impact on Q1 and Q2 are now scheduled through to the year-end, and now also into 2022/23.

Discussion is due now (date to be confirmed) with SG to review 2021/22 Q1-Q3, the likely requirement for Q4, and initial estimates now for 2022/23 – for which clarity is still required as to what SG funding will be available and how it will be reviewed / allocated.

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

3 ASSESSMENT - FINANCE

3.1 Financial Governance and SG allocation

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

While it was initially anticipated that Covid costs for 2021/22 would be reported monthly to SG for allocation agreement in the same way as Q3 and Q4 of 2020/21, instead we have reported Covid costs through Q1-Q3, with allocations therefrom agreed in a similar way to that which was applied in August 2021 for the early months of the Covid crisis, and Q4 is now determined on an estimate towards the March 2022 year-end.

We have had meetings with our SG finance team to review this position and to ensure that sufficient clarity has been provided of any cost pressures. Our reporting and forecasting is in line with SG expectations and our follow-up discussions are confirming support to cover our Covid-related costs through to March 2022.

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

3.2 Covid19 specific costs

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

i. Overtime costs Q1-3 £60k – additional overtime incurred each month due principally to the increased levels of staff absence arising from Covid absences (classified as special leave), together with an element of high level clinical demands. (This is principally re Nursing, but includes £10k re Infection control and Security).

ii. Student nursing recruitment £450k – these costs are to be confirmed with SG with regard to the correct allocation of costs of additional student nurses to confirm if as expected these are to be funded directly through the Covid funding as in 2020/21. This is also a key area for consideration for 2022/23.

iii. Additional deep cleaning £10k – being extra cleaning requirements specific to rooms for patients with positive Covid test results.

iv. Telephony, related IT and digital costs £6k – being the costs of teleconferencing and other remote communication costs now being incurred – this is now much reduced due to the wider use of Teams.

v. Estates/facilities costs £47k – including the requirement for additional food containers for the appropriate provision of safe catering.

vi. "Dual running" / Infection Control staff costs – £160k – relating to Covid support posts and other related costs ongoing.

vii. Perimeter project contingent costs - while an element of delay was incurred due to the site access restrictions in lockdown, the final value is under evaluation for final agreement as the actual cost, while relating to this period, will be charged in 2021/22. Should further restrictions be applied in February / March 2022 then this will require additional consideration.

3.3 Covid19 costs – vaccinations programme

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

4 RECOMMENDATION

The Board is asked to note this report

MONITORING FORM

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

Paper No. 22/04

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	24 February 2022
Agenda Reference:	Item No: 8
Sponsoring Director:	Director of Security, Resilience and Estates
Author(s):	Risk Management Facilitator
Title of Report:	Corporate Risk Register Update
Purpose of Report:	To note the Risk Register update and agree new additions to the Corporate Risk Register

1 SITUATION

A corporate risk is a potential or actual event that:

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

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

2 BACKGROUND

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

3 ASSESSMENT

3.1 Current Corporate Risk Register - See appendix A.

3.2 Review Dates

All CRR Risks are currently in date

3.3 Proposed Risks for inclusion on Corporate Risk Register

Following a review by the Risk Management Facilitator with the Head of Risk and Resilience, Head of eHealth and Director of Finance and eHealth the following risks are being proposed for inclusion on the CRR:

Currently **FD91 - IT System failure or breach** covers the risk of an IT system failure or breach, breach and failure to comply with data protection arrangements and maintenance of system backups. For clarity and ensuring the correct measures are in place to manage these risks the review team is proposing FD91 is split into the following:

Maintenance of System Backups – This will be monitored by eHealth on their Local Risk Register. Risk is deemed to be Low due to the triple backup measures that are in place across the site.

IT System Failure – This risk will exclusively focus on managing the risk of an outage across the site and the measures TSH has in place to mitigate that. This will be managed by Director of Finance and eHealth and the Head of eHealth on the CRR.

Failure to Comply with Data Protection Arrangements – This risk will manage the hazards faced by TSH if certain aspects of Data Protection Laws are not managed effectively across the board. This will include training, information governance and securing data (fairwarning, firewall etc). This will be developed and managed by Director of eHealth and Performance and Information Governance & Data Security Officer on the CRR.

3.4 Corporate Risk Register Updates

SD53 - Serious security breaches (eg escape, intruder, serious contraband) – has been decreased from Extreme x Unlikely (High) to Extreme x Rare decreasing the overall grading of the risk to Medium. All control measures have proved effective and there have been no incidents to date or equipment failures. Daily monitoring of control measures is ongoing. As such the risk can now be reduced to medium.

Ref	Initial Grading	Current Grading	Target Grading	Owner	Next Review	Group Monitoring Risk	Review Frequency	Change
Corporate SD 53	Extreme x Unlikely	Extreme x Rare	Extreme x Rare	Security Director	01/01/22	CMT/Risk and Resilience Committee	Monthly	Likelihood ↓

FD97 – Management of smartphone access to hospital and systems – has been reworded from 'unmanaged smart telephones' access to The State Hospital information and systems' due to the mobile access systems no longer being unmanaged. Phone users now have only an approved list of apps they are able to use and are no longer able to access hospital systems (Other than Office 365 apps – email, teams etc). Users are also unable to erase contents of phone at any time. The hospital has also managed telephone access to the hospital by utilising a scanner system which allows staff to check the phones user and eligibility to bring into the hospital which will further reduce the risk. Risk still remains low – incidents monitored through Datix.

Ref	Initial Grading	Current Grading	Target Grading	Owner	Next Review	Group Monitoring Risk	Review Frequency	Change
Finance FD 97	Major x Likely	Moderate x Rare	Moderate x Rare	Finance Director	30/08/22	CMT/Risk and Resilience Committee	6 monthly	Impact ↓

FD96 Cyber security breach - Upon review it was noted that the many upgrades to the system including: The implementation of Windows 10 devices across the hospital which brings protection software to prevent malware encryption virus by using Advanced Threat Protection (ATP). This system is also monitored nationally (SWAN) which allows for information sharing across boards. While TSH has these systems remain in place the risk of this type of incident happening still remains unlikely due to the nature of these types of attacks on organisations. Similarly, the impact of this would still likely be at minimum 'Moderate' to TSH. Through discussions with risk owners the decision was made to change the target level to Moderate x Unlikely (Medium) which will bring the risk to target level as the risk is being managed as effectively as is currently possible. The risk will continue to be monitored quarterly and updated as required.

Ref	Initial Grading	Current Grading	Target Grading	Owner	Next Review	Group Monitoring Risk	Review Frequency	Change
Finance FD 96	Moderate x Unlikely	Moderate x Unlikely	Moderate x Unlikely	Finance Director	30/05/22	CMT/Risk and Resilience Committee	Quarterly	Target Updated

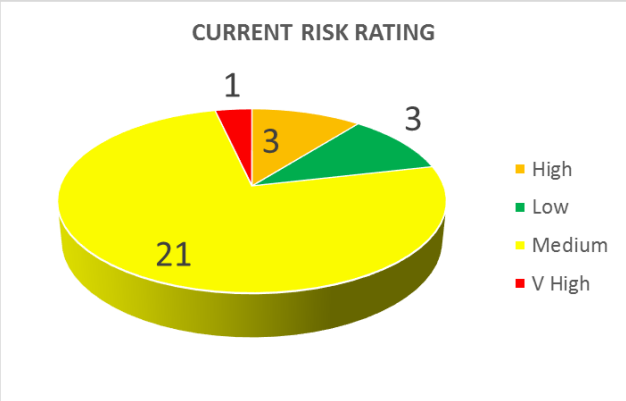
FD90 – Failure to implement a sustainable long term model – Work is ongoing surround this risk, further control measures will be reviewed quarterly and risk updated as appropriate.

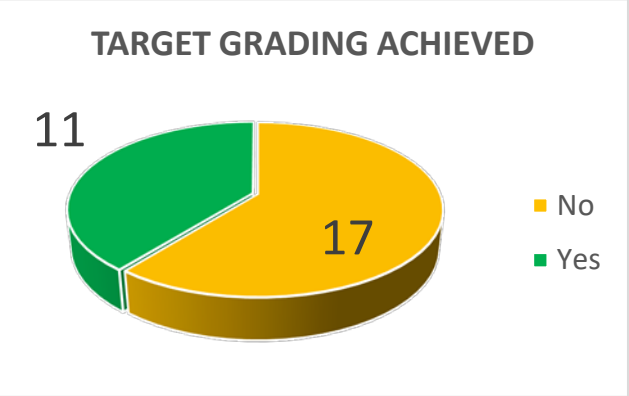
3.5 High and Very High Risk – Monthly Update

The State Hospital currently has 1 Very High risk and 4 High graded risks, latest updates are below:

Risk	Current Grading	Latest Update – December 2021
CE14: The risk that Coronavirus (Covid-19) could affect The State Hospitals primary aim to provide high quality, effective care and treatment and maintain a safe and secure environment for patients and staff	**Major X Almost Certain**	CMT agreed to keep to move risk to Very High (likelihood up from likely to almost certain) due to potential risk to staff numbers. Risk Assessment reviewed at CMT fortnightly and Infection Control Monthly. Latest updates include cover monitoring of Omicron Variant.
ND70: Failure to utilise our resources to optimise excellent patient care and experience	**Moderate x Likely**	Staffing issues continue to affect TSH. Daily meeting takes place to monitor staff resources in real time managed through the 'Safe to Start' Process. Development of Nurse Bank Latest Update: Engagement sessions taking place 16th & 17th, communication sent out to all staff. Recruitment onboarding underway and progressing well.
ND71: Failure to assess and manage the risk of aggression and violence effectively	**Major X Possible**	**Risk is at target level:** Continues to be managed effectively with existing procedures and training. Violence and aggression incidents monitored by Risk & Resilience Team. Level 3 PPE training has been approved – training paused due to procurement issues with equipment.
MD30**:** Failure to prevent/mitigate obesity	**Major X Likely**	Obesity figures look better than last month – **88% down from 93%**
SD53: Serious security breaches (eg escape, intruder, serious contraband)	**Extreme X Unlikely**	Has been decreased from Extreme x Unlikely (High) to Extreme x Rare (Medium) decreasing the overall grading of the risk to Medium. All control measures have proved effective and there have been no incidents to date or equipment failures. Daily monitoring of control measures is ongoing. As such the risk can now be reduced to medium. ***As risk is now medium it will no longer be monitored monthly**

3.6 Risk Distribution





Currently 11 Corporate Risks have achieved their target grading, with 17 currently not at target level. Since the last report, the grading of 2 risks (SD53 and FD96) have met target level, details in section 3.4.

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

"The Hospital tolerates **Medium** and **Low** risks as part of the risk appetite mentioned above. **High** and **Very High** risks are treated as unacceptable and will require further action and monitoring from the relevant owner or group"

A work plan is underway to focus on risks not at target level in Q4 2021/22 into Q1 2022/23, this will be taken forward by the Risk Management Facilitator and Head of Risk and Resilience who will liaise with risk owners. The work plan will involve working with risk owners and action officers to ensure risks are up to date and relevant, review ongoing work to reduce risk to target level and ensure appropriate grading. The aim is to meet with one directorate each month going forward with updates given to CMT and The Board through this report.

As part of this work plan all Finance Directorate risks have been reviewed in depth with substantial updates to each risk noted, the main points are detailed in sections 3.3 and 3.4.

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

Review Periods:

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

4 RECOMMENDATION

The Board are invited to note and review the current Corporate Risk Register and to feedback any comments and/or additional information members would like to see in future reports to the group and the Board.

Paper No. 22/04

MONITORING FORM

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

- Blue denotes risk that will be leaving the CRR

Appendix A

Ref No.	Category	Risk	Initial Risk Grading	Current Risk Grading	Target Risk Grading	Owner	Action officer	Next Scheduled Review	Governance Committee	RA	AP	Monitoring Frequency	Movement Since Last Report
Corporate CE 10	Reputation	Severe breakdown in appropriate corporate governance	Extreme x Possible	Extreme x Rare	Extreme x Rare	Chief Executive	Board Secretary	30/03/22	Board	Y/Y	N/A	Quarterly	-
Corporate CE 11	Health & Safety	Risk of patient injury occurring which is categorised as either extreme injury or death	Extreme x Possible	Extreme x Rare	Extreme x Rare	Chief Executive	Chief Executive	30/04/22	Clinical Governance	Y/Y	N/A	Quarterly	-
Corporate CE 12	Strategic	Failure to utilise appropriate systems to learn from prior events internally and externally	Major x Possible	Moderate x Possible	Moderate x Unlikely	Chief Executive	Risk Management Team Leader	30/04/22	Risk and Resilience Group	Y/Y	N/A	Quarterly	-
Corporate CE 13	Strategic	Inadequate compliance with Chief Executive Letters and other statutory requirements	Moderate x Unlikely	Moderate x Rare	Moderate x Rare	Chief Executive	Board Secretary	30/03/22	CMT	Y/Y	N/A	6 monthly	-
Corporate CE 14	ALL	The risk that Coronavirus (Covid-19) could affect The State Hospitals primary aim to provide high quality, effective care and treatment and maintain a safe and secure environment for patients and staff.	Major x Almost Certain	Major x Almost Certain	Minor x Possible	Chief Executive	Chief Executive	30/03/22	CMT	Y/Y		Fortnightly	Likelihood ↑
Corporate MD 30	Medical	Failure to prevent/mitigate obesity	Major x Likely	Major x Likely	Moderate x Unlikely	Medical Director	Lead Dietitian	01/03/22	Clinical Governance Committee	Y/Y	Y/Y	Monthly	-
Corporate MD 32	Medical	Absconsion of Patients	Major x Unlikely	Major x Rare	Moderate x Rare	Medical Director	Associate Medical Director	01/03/22	CMT	Y/Y	N/A	Quarterly	-
Corporate MD 33	Medical	Potential adverse impact arising from clinical presentation out of hours with no doctor on site (5pm - 6pm)	Moderate x Unlikely	Moderate x Unlikely	Moderate x Unlikely	Medical Director	Associate Medical Director	01/03/22	CMT	Y/Y	N/A	Quarterly	-
Corporate MD 34	Medical	Lack of out of hours on site medical cover	Major x Unlikely	Major x Unlikely	Major x Unlikely	Medical Director	Associate Medical Director	01/03/22	CMT	Y/Y	N/A	Quarterly	-

Corporate SD 50	Service/Business Disruption	Serious Security Incident	Moderate x Possible	Moderate x Possible	Moderate x Possible	Security Director	Security Director	01/03/22	CMT	Y/Y	N/A	Quarterly	-
Corporate SD 51	Service/Business Disruption	Physical or electronic security failure	Extreme x Unlikely	Major x Unlikely	Major x Rare	Security Director	Security Director	01/03/22	Audit Committee	Y/Y	Y/Y	Quarterly	-
Corporate SD 52	Service/Business Disruption	Resilience arrangements that are not fit for purpose	Major x Unlikely	Moderate x Unlikely	Moderate x Rare	Security Director	Security Director	01/03/22	CMT	Y/Y	N/A	Quarterly	-
Corporate SD 53	Service/Business Disruption	Serious security breaches (eg escape, intruder, serious contraband)	Extreme x Unlikely	Extreme x Rare	Extreme x Rare	Security Director	Security Director	01/03/22	CMT/Risk and Resilience Committee	Y/Y	Y/Y	Quarterly	Likelihood ↑
Corporate SD 54	Service/Business Disruption	Climate change impact on the State Hospital	Minor x Possible	Moderate x Possible	Minor x Possible	Security Director	Head of Estates and Facilities	01/03/22	CMT/Risk and Resilience Committee	Y/Y	N/A	Quarterly	-
Corporate SD 55	Service/Business Disruption	Negative impact of EU exit on the State Hospital	Moderate x Unlikely	Moderate x Unlikely	Moderate x Rare	Chief Executive	Security Director	01/03/22	CMT	Y/Y	N/A	Quarterly	-
Corporate SD 56	Service/Business Disruption	Water Management	Major x Unlikely	Major x Unlikely	Major x Rare	Security Director	Head of Estates and Facilities	01/03/22	Infection Control Committee	Y/Y	N/A	Quarterly	-
Corporate SD57	Health & Safety	Failure to complete actions from Cat 1/2 reviews within appropriate timescale	Moderate x Possible	Moderate x Possible	Moderate x Unlikely	Finance & Performance Director	Head of Corporate Planning and Business Support	01/04/22	CMT	Y/Y	N/A	Quarterly	-
Corporate ND 70	Service/Business Disruption	Failure to utilise our resources to optimise excellent patient care and experience	Moderate x Possible	Moderate x Likely	Minor x Unlikely	Director of Nursing & AHP	Director of Nursing & AHP	28/02/22	CMT	Y/Y	Y/Y	Quarterly	-
Corporate ND 71	Health & Safety	Failure to assess and manage the risk of aggression and violence effectively	Major x Possible	Major x Possible	Major x Possible	Director of Nursing & AHP	Director of Nursing & AHP	28/02/22	CMT	Y/Y	Y/Y	Monthly	-
Corporate ND 73	Service/Business Disruption	Lack of SRK trained staff	Moderate x Likely	Moderate x Possible	Moderate x Unlikely	Director of Nursing & AHP	Director of Nursing & AHP	01/03/22	PMVA Group and CMT	Y/Y	N/A	Quarterly	-

Corporate FD 90	Financial	Failure to implement a sustainable long term model	Moderate x Unlikely	Moderate x Unlikely	Moderate x Rare	Finance & Performance Director	Finance & Performance Director	30/05/22	Audit Committee, RF&P Group & CMT	Y/Y	N/A	Quarterly	-
Corporate FD 91	Service/Business Disruption	IT system failure/breach	Moderate x Possible	Moderate x Possible	Minor x Possible	Finance & Performance Director	Head of eHealth	30/05/22	Information Governance Group & CMT	Y/Y	N/A	Quarterly	-
Corporate FD 94	Service/Business Disruption	Inadequate data centre	Moderate x Likely	Moderate x Rare	Moderate x Unlikely	Finance and Performance Director	Head of eHealth	30/07/22	CMT/ Risk and Resilience Committee	Y/Y	N/A	Quarterly	-
Corporate FD 96	Service/Business Disruption	Cyber Security/Data Protection Breach due to computer infection	Moderate x Unlikely	Moderate x Unlikely	Moderate x Rare	Finance and Performance Director	Head of eHealth	30/05/22	CMT/Risk and Resilience Committee	Y/Y	N/A	Quarterly	-
Corporate FD 97	Reputation	Unmanaged smart telephones' access to The State Hospital information and systems.	Major x Likely	Moderate x Rare	Moderate x Rare	Finance and Performance Director	Head of eHealth	30/07/22	Information Governance Group & CMT	Y/Y	Y/Y	6 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	01/03/22	CMT	Y/Y	N/A	Quarterly	-
Corporate HRD 111	Reputation	Deliberate leaks of information	Major x Possible	Major x Unlikely	Moderate x Unlikely	Interim HR Director	Interim HR Director	01/03/22	CMT	Y/Y	Y/N	Quarterly	-
Corporate HRD 112	Health & Safety	Compliance with Mandatory PMVA Level 2 Training	Major x Unlikely	Moderate x Possible	Major x Rare	Interim HR Director	Training & Professional Development Manager	01/03/22	H&S Committee	Y/Y	N/A	Quarterly	-

Paper No. 22/05

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	24 February 2022
Agenda Reference:	Item No: 9
Sponsoring Director:	Medical Director
Author(s):	Head of Corporate Planning and Business Support Consultant Psychiatrist
Title of Report:	Clinical Model – Progress Update
Purpose of Report:	For Noting

1 SITUATION

Planning for Implementation of the Clinical Model was in an advanced stage prior to the Coronavirus pandemic. Work was paused in March 2020 and restarted in June 2021 to consider the current context, previous work carried out and what the future conditions would require prior to any restart. Planning and engagement has progressed with papers presented to TSH Board on 26th August and 27th October 2021. This paper updates the Board on progress.

2 BACKGROUND

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

Planning progressed with mapping exercises in June and October. These exercises provided evidence that the model of 2 admission wards, 4 treatment and recovery wards, 2 transition wards and 2 ID wards continue to be appropriate. However, the patient population for Major Mental Illness (MMI) patients continues to exceed the beds available for this group in the Clinical Model. A range of options for addressing this issue were considered and an agreement has been reached that some MMI may need to board in the ID wards if this situation continues when implementation takes place.

3. ASSESSMENT

The Board were presented with a range of actions and issues in October 2021 that required further exploration and development prior to implementation.

These were:

- Implementation planning
- Staff, Patient and wider stakeholder engagement
- Financial planning
- Further exploration on integration of the Clinical Model and QI activity project
- Agreement on governance structure to support planning and implementation
- Wider system consideration

A project group has formed and initial planning has taken place, however progress has been limited due to the impact of the omicron variant and subsequent establishment of Incident Command in December 21 / January 22.

CMT met in February 2022 and considered priority actions to progress planning and sequencing of actions in preparation for the implementation of the Clinical Model. These are:

- Engagement – staff, patients, carers, Board, Forensic Network and Scottish Government
- Financial analysis with associated deep dive into workforce requirements
- Revision and development of the clinical guidance documents ensuring patient activity is a key feature of all ward and hubs
- Clarity about planning assumptions
- Description of the management model to support implementation of the new model

3 RECOMMENDATION

Board members are asked to note the limited progress made due to the impact of the omicron variant and proposed next steps on the restart of the Clinical Model.

MONITORING FORM

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

Paper No. 22/06

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	24 February 2022
Agenda Reference:	Item No: 10
Sponsoring Director:	Medical Director
Author(s):	Chair and the PHSG/SHC Group and Lead Dietitian
Title of Report:	Supporting Healthy Choices – Progress Update
Purpose of Report:	For Noting

1 SITUATION

The Supporting Healthy Choices Group is focused to support TSH in managing obesity as rates over the last 6-12 months continue to prevail at between 83 to 93% of patients being overweight or obese with the risk of associated comorbidities and known increased risk of morbidity and mortality from the current COVID -19 pandemic.

2 BACKGROUND

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

3 ASSESSMENT

Of the actions agreed to maintain/commence;

Action	Progress
Monthly weight/BMI monitoring of patients continues,	Ongoing, reported into Rio and reports from such and used for Tableau data
Review provision of hospital shop bags,	Skye centre action (JG)
Patient related information on aspects related to health via use of physical health education boards on all wards.	Actioned currently monthly by dietetics team
Review of weight management pathway with include information on national weight management tiers and dissemination to wards and health centre for staff education,	Actioned Oct ’21.
Audit of patient menu choices to identify if colour coding in line with FSA national coded increases uptake of healthier/healthy choices,	Completed by clinical effectiveness, results to PHSG March ’22.
Funding for health psychologist post (versus trainee post),	Post due to be advertised – action by Head of psychology

Scoping of weight history screening tools to assess all patients within 6 months' admission,	Currently ongoing by dietetic team
Annual takeaway audit (TBC date of last)	Annual audit ceased when practice improved and guidelines for patients' orders in place
Full length mirrors have been agreed for communal areas and spend agreed to purchase.	Agreed – action by estates
Counterweight plus (meal replacement plan) has been maintained in practice for designated patients	Ongoing. Bid for 2022/3 funding and end of year report due April/May '22.
Work to progress the move from Health and Wellbeing plans (HWP) to Nutrition and Physical Health Care plans (NHCP) is ongoing.	Currently ongoing with Nursing practice development and prof Nursing Officer.

In addition the programme manager post has been assessed and will now progress to advert.

4 RECOMMENDATION

The Board to note the current progress and situation.

To support the recruitment of a project manager to progress with the outstanding SHC actions during 2022/3.

Paper No. 22/06

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Supports the implementation SHC programme
Workforce Implications	As noted re recruitment of project manager
Financial Implications	As above
Route To The Board Which groups were involved in contributing to the paper and recommendations	Corporate Management Team and Clinical Governance Committee
Risk Assessment (Outline any significant risks and associated mitigation)	No specific risk outlined in addition to previous reporting
Assessment of Impact on Stakeholder Experience	Impact on patient care as outlined
Equality Impact Assessment	No additional update to previous reporting
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do)	n/a
Data Protection Impact Assessment (DPIA) See IG 16	Tick One √ There are no privacy implications. □ There are privacy implications, but full DPIA not needed □ There are privacy implications, full DPIA included

Paper No. 22/07

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	24 February 2022
Agenda Reference:	Item No: 11
Sponsoring Director:	Medical Director
Author(s):	Head of Corporate Planning and Business Support
	Head of Clinical Quality
Title of Report:	Quality Assurance and Quality Improvement
Purpose of Report:	For Noting

1 SITUATION

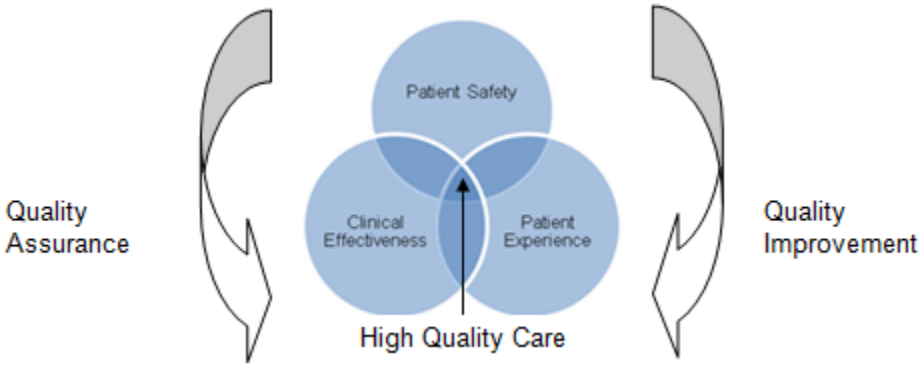
This report provides an update to The State Hospital Board on the progress made towards quality assurance and improvement activities since the last Board meeting in December 2021. The report highlights activities in relation to QA and QI and outlines how these relate to strategic planning and organisational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

2 BACKGROUND

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

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

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



3 ASSESSMENT

The paper outlines key areas of activity in relation to:

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

4 RECOMMENDATION

The Board are asked to note the content of this paper

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

	□ There are privacy implications, full DPIA included.

QUALITY ASSURANCE AND IMPROVEMENT IN THE STATE HOSPITAL

FEBRUARY 2022

ASSURANCE OF QUALITY

Clinical Audit

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

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

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

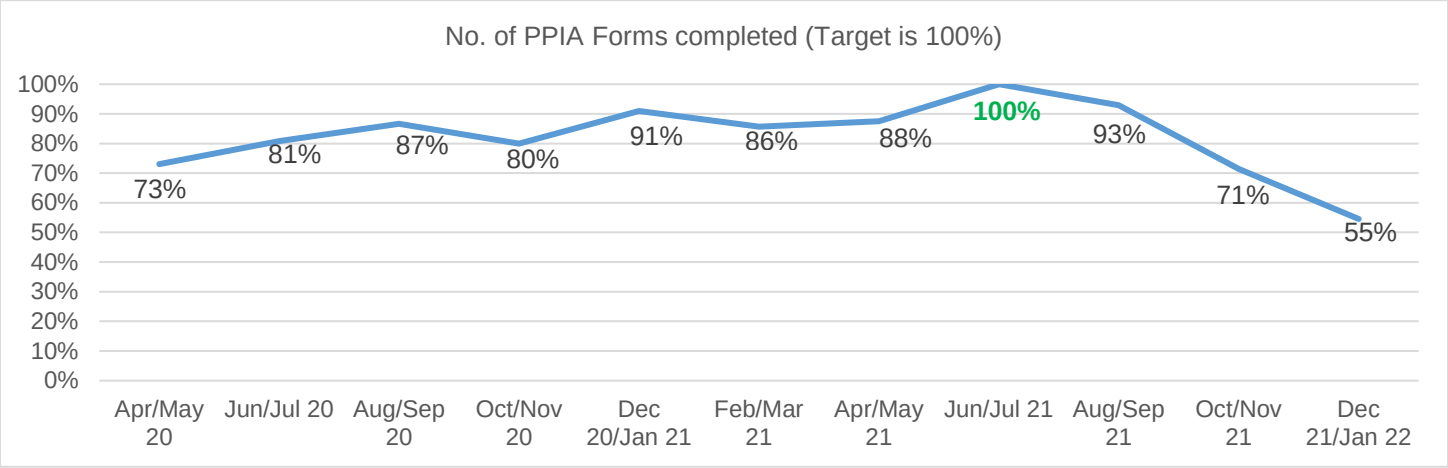
Post Physical Intervention Audit

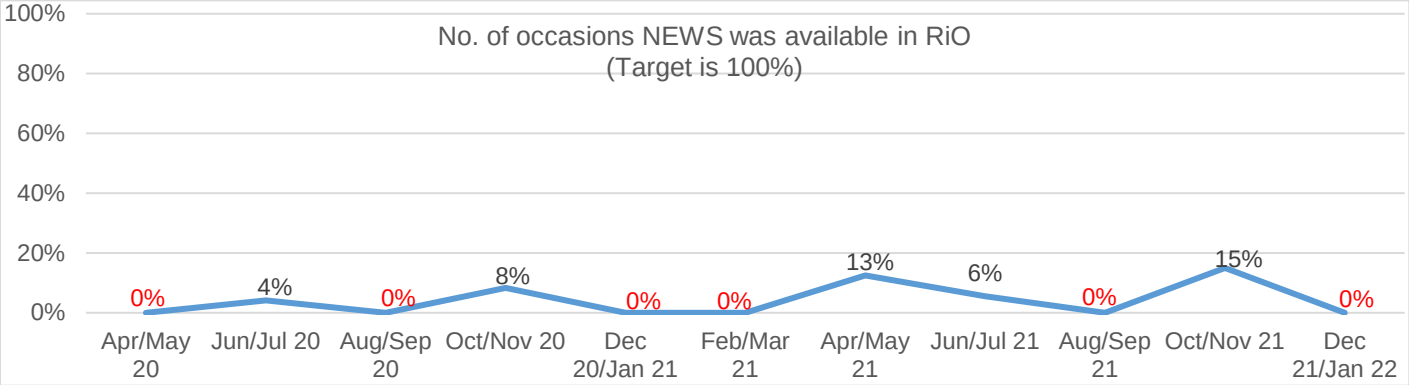
Areas Showing Improvement

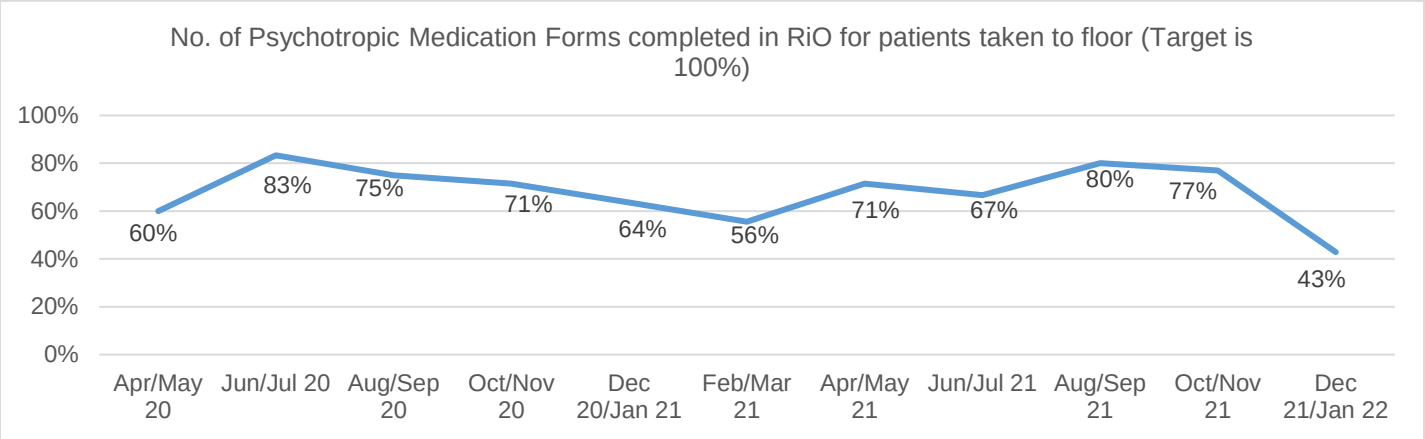
- Of the 6 completed PPIA forms all (100%) had been closed off in RiO
- For the 2 occasions on Datix where injuries were reported a PPIA form was available for both (100%)

Areas for Improvement

- Of 11 occasions where secure holds were applied, there were Post Physical Intervention Assessment (PPIA) forms completed by Senior Clinical Cover on RiO available for 6 (55%) occasions. This is a continued decrease from 100%, 93% and 71% in the previous 3 audit periods
- For the 2 instances where injuries were recorded on Datix, the information did not match with the injury site details recorded on the PPIA form on 1 (50%) occasion
- Of the 9 occasions where a patient had been taken to the floor and observations should have been recorded within the NEWS, there were no (0%) completed NEWS available within RiO.
- There were 7 (78%) occasions following physical intervention where a PRN was administered, 3 (43%) of these were recorded on Psychotropic Medication Forms within RiO.







Due to the concerns with this data and the downward trends we are starting to see, the report was tabled at the Patient Safety Group where a number of change ideas were agreed. This audit will be repeated to see if the change ideas have resulted in any improvements.

Observation Level Audit

Areas showing improvement

- For the 22 patients that were placed on Level 2 Observations, 82% of patients had evidence of review discussions taking place. If only the policy directives were audited there would be a gap in supporting evidence of 18%.
- For the 8 patients on level 3 observations, 100% of patients had evidence found within the note types of review discussions taking place.
- For the 8 patients on level 3 observations Medical progress notes were reviewed to find evidence that observation level review discussions had taken place between nursing and medical staff. Evidence was found on 88% of occasions. If only the policy were audited there would be a gap in supporting evidence of 12%.
- For the 8 patients on level 3 observations Nursing progress notes were reviewed to find evidence that observation level review discussions had taken place between nursing and medical staff. Evidence was found on 88% of occasions. If only the policy were audited there would be a negative difference in data of 12%.
- Of 9 RMO's that had patients on increased observation levels there is a requirement for 6 of them to use the note type for level 3 patients. This was carried out by 5 (83%) of the relevant RMO's to varying degrees.
- The observation section of the CTM Form was completed on 65 (87%) occasions.

Areas for Improvement
All areas that required improvement have seen improvement since the last audit cycle

The Policy amendment recommended in the previous report was approved and has now been implemented making it clear that if a patient goes between level 3 and seclusion then an appendix 4 must be completed after 28 days to fully review the patients care.

Record Keeping Audit

Unvalidated entries
Over the full month of November there were only 10 entries invalidated within RiO. This continues to be excellent compliance with the standards and a significant improvement from baseline when we were seeing 561 unvalidated entries.

Scanned documents placed in the correct patient's electronic record (last 10 for each patient)
We are seeing excellent compliance with this with November's data showing 98% compliance.

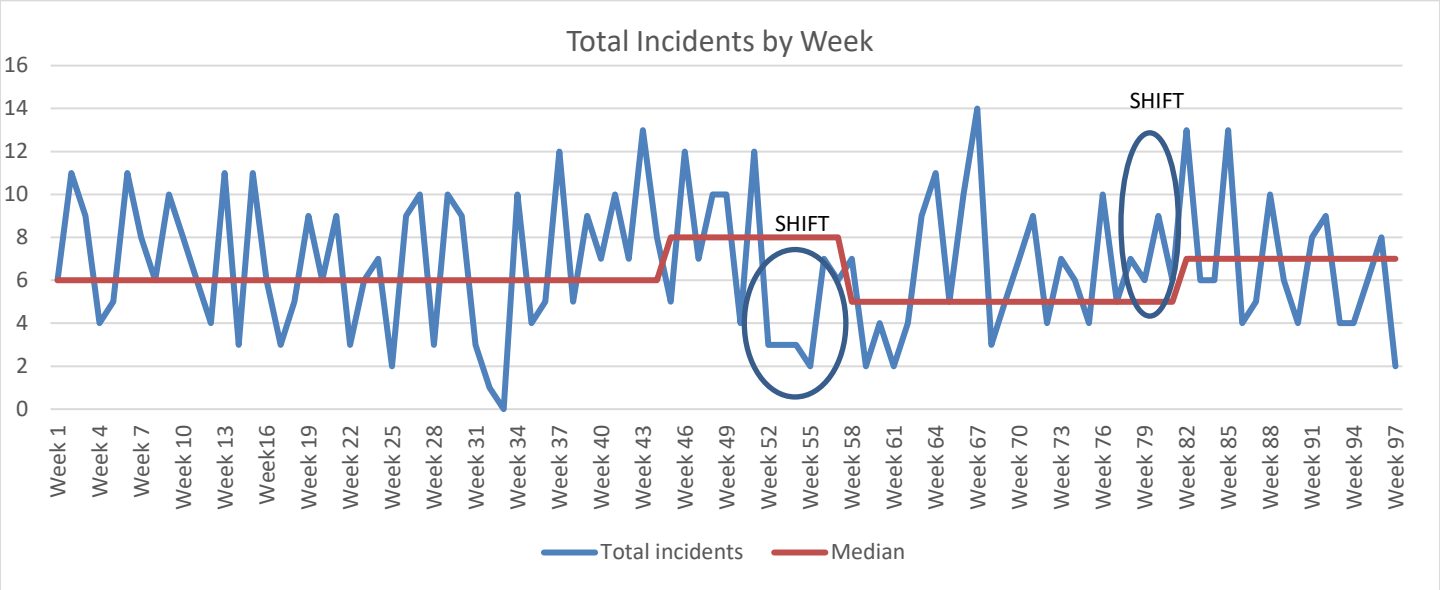
Nursing Entry on Every Shift
We are seeing excellent compliance with this with November's data showing over 99% compliance

There are a number of audits that are being prepared for approval at their commissioning groups. Due to the pausing of these groups at the start of January the audit reports will not be approved until the next meeting. The audits that are being prepared are compliance with T2/T3, diabetes audit and menu option audit.

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

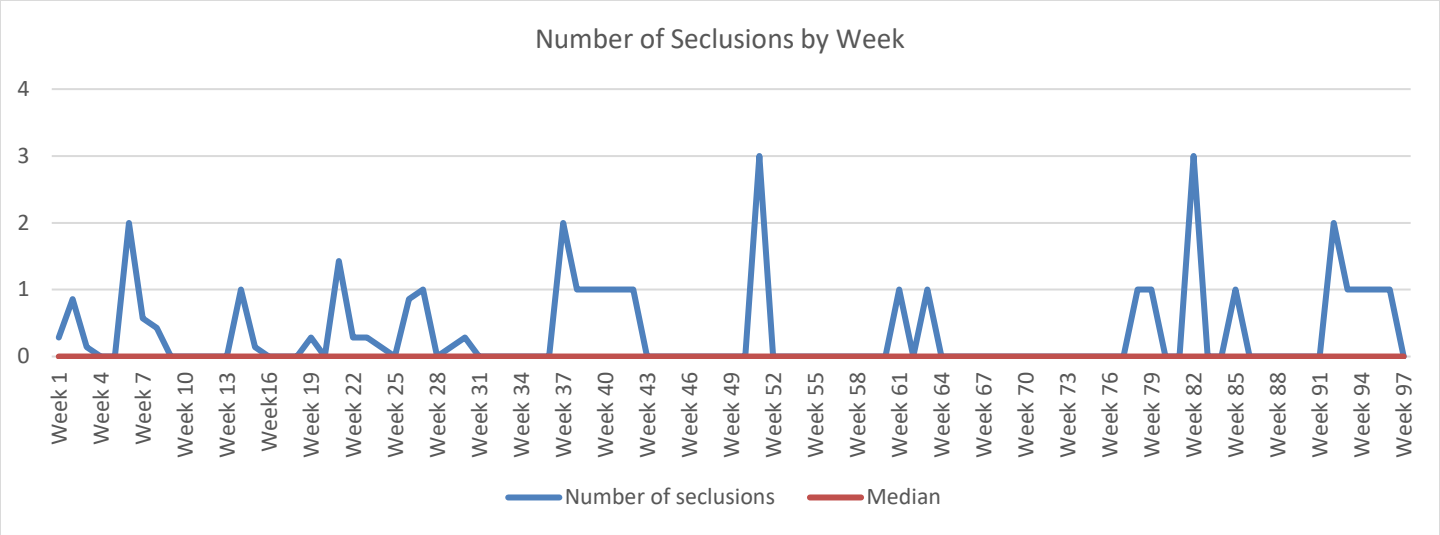
Datix assaults, attempted assaults and behaviour

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



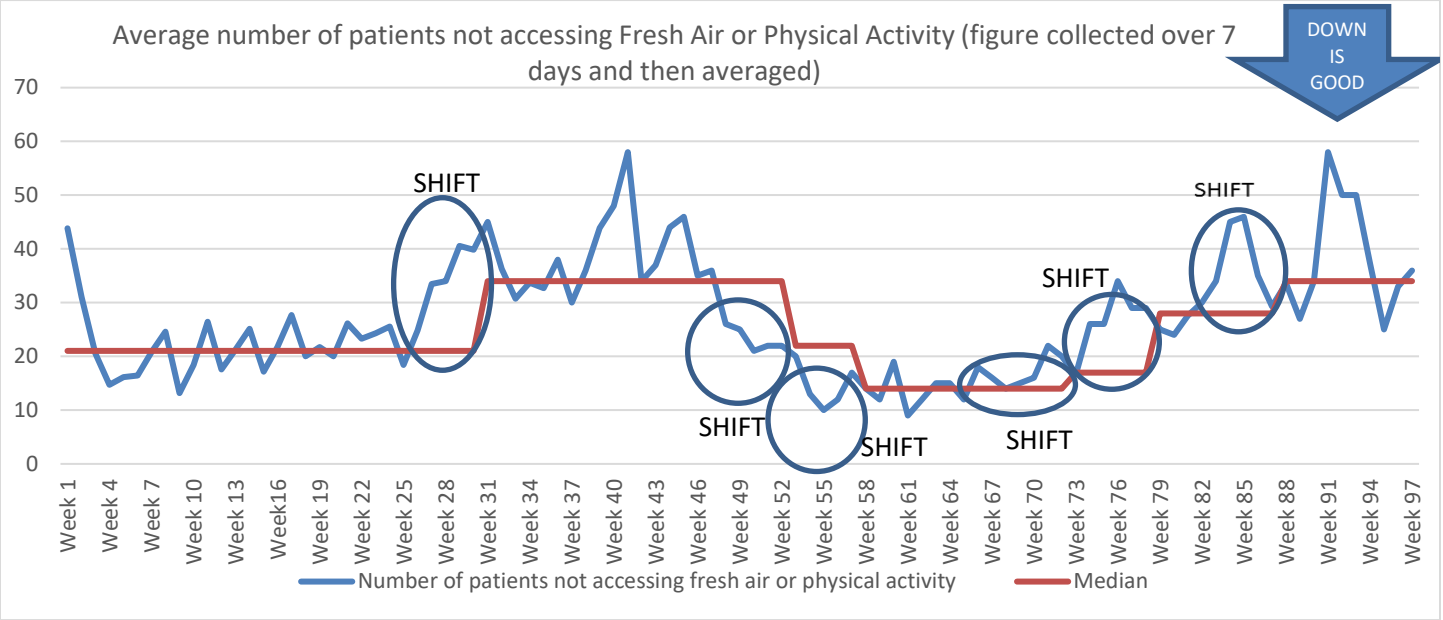
Seclusions

As can be seen the seclusion data continues with random variation. We saw a period of no seclusions between week 64 and week 77. Week 82 saw the number of seclusions increase to 3, however this was 2 patients with one patient being secluded twice within the 7 day period. Over the last couple of weeks we have seen 3 patients being secluded, one of these being a new admission.



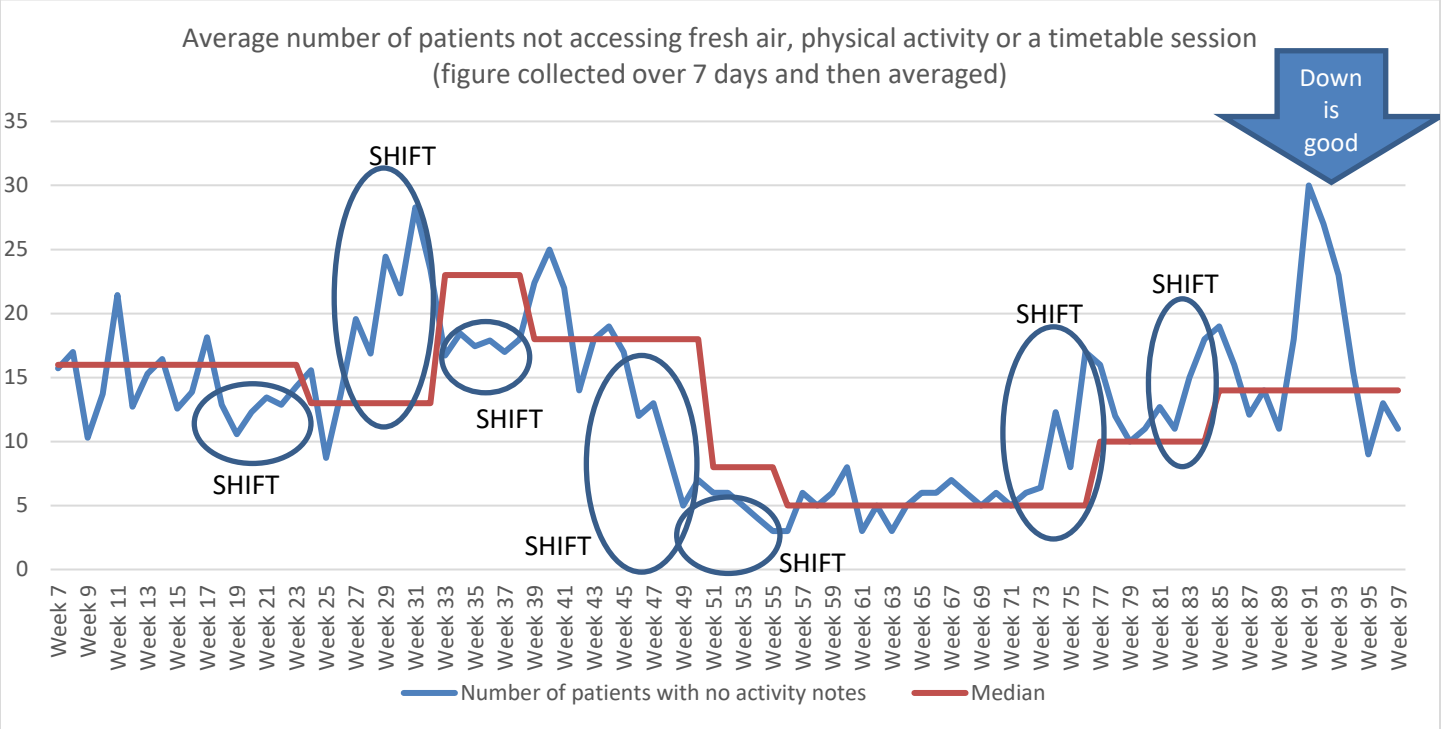
Patients not accessing Fresh air or Physical Activity (this is an average daily figure)
This indicator looks at both the fresh air data from PMTS and timetables and the physical activity data from RiO and highlights the patients that have had no fresh air or physical activity.

As can be seen we have seen 2 positive shifts in the data between week 48 and 53 (26th February and 8th April) and week 53 and 58 (8th April and 13th May). The first positive shift moved the median from 34 to 22 and the second moved it from 22 to 14. We have seen 4 negative shifts in the data between week 26 and 31 (22nd September and 2nd November), week 66 and 72 (2nd July and 13th August), week 73 and 79 (28th August and 7th October) and week 82 and 88 (22nd October and 9th December). The median has moved to 34. The negative shifts correlate with ward staff shortages in July and the weather deteriorating at the other 3 shifts.



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

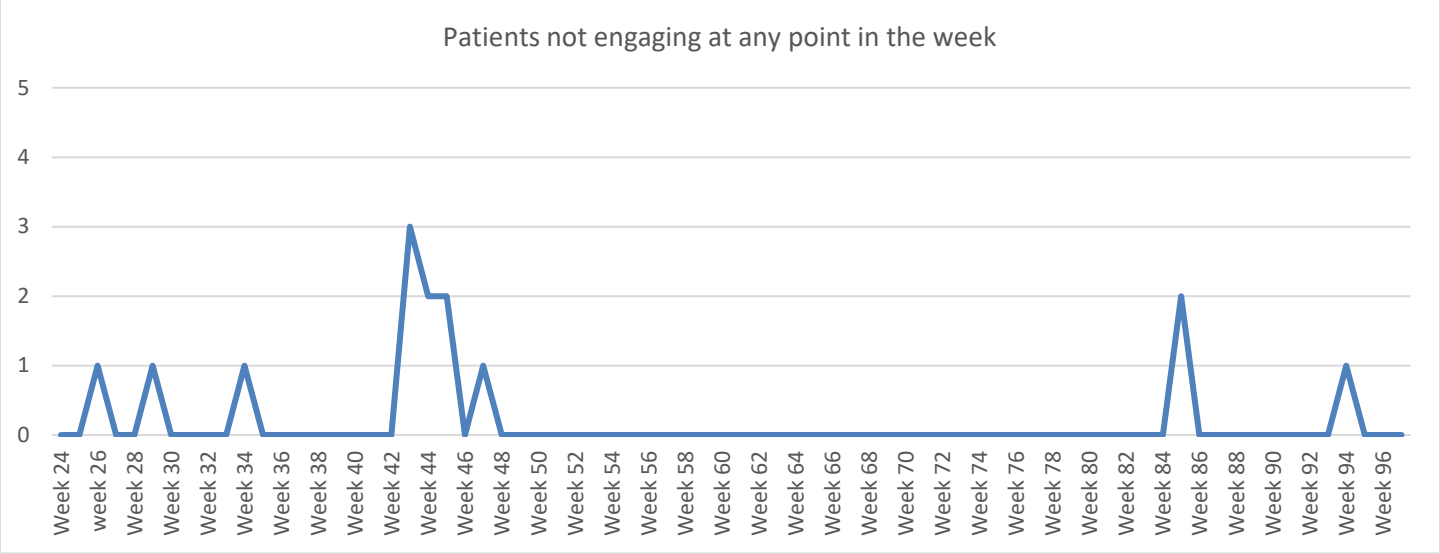
One of the main purposes of collecting the daily indicator data was to ensure that there were limited patients that were not engaging with some form of activity i.e. fresh air, physical activity or a timetable session on a daily basis. From week 7, 12th May we started to monitor this. As can be seen, the latest negative shift was seen between week 77 and 85 (24th September and 18th November). The shift came at a time when we were starting to see inclement weather, challenges with ward staff shortages, an increase in the additional staff required to support patients on level 3 observations and patients and wards being isolated due to positive covid results.



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

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

Patient not engaging with fresh air, physical activity or a timetable session at any point in the week
When we look to see how many patients have had either fresh air, physical activity or a timetable session at any point in the week the data shows all patients had engaged with some form of activity at some point in the week since week 48. In week 85 however we had 2 patients that did not engage at any point in the week. Both these patients were in isolation due to testing positive for covid. Week 94 saw one patient note accessing fresh air, physical activity or a timetable activity but it should e noted that this patients was boarding out at University Hospital Wishaw due to their poor physical health.



The Operating Model Monitoring Group have commissioned 2 further reports in November in response to the data. The first is a weekly report from the Skye Centre to give context to the data and also a report that shows the activities patients have had on the days their wards have been closed – this is to see variation across the site and good practice that can be shared. The table below is taken from the week 97 report.

Date	Ward Closed	Closure Detail	Patients having at least 1 timetable activity
04/02/2022	Arran 1	Partial – closed from 1600	6 of 10
06/02/2022	Arran 1	Partial – closed from 1630	10 of 10
08/02/2022	Arran 1	Partial – closed from 0845 to 1130	10 of 10
09/02/2022	Arran 1	Closed – back shift	11 of 11
09/02/2022	Arran 2	Closed – back shift	11 of 11
08/02/2022	Iona 1	Partial – closed from 0845 to 1130	9 of 11

Date	Ward Closed	Closure Detail	Patients having at least 1 timetable activity
09/02/2022	Iona 1	Partial – closed from 7pm	5 of 11
09/02/2022	Iona 3	Partial – closed from 7pm	11 of 12
04/02/2022	Lewis 1	Partial – closed from 140 to 1500 for outing	6 of 10
04/02/2022	Lewis 2	Closed – back shift	11 of 11
05/02/2022	Lewis 3	Partial – closed from 1630	10 of 12
07/02/2022	Lewis 3	Closed – back shift	12 of 12
09/02/2022	Lewis 3	Closed back shift	12 of 12
09/02/2022	Lewis 3	Partial – closed from 5pm	9 of 9

Ward Isolations

Ward Isolation periods and numbers of patients and staff positive cases.

Ward isolated	Date of isolation (ward closed & re-opened)	Positive cases	
Iona 2	12.12.2021 – 10.01.2022	7 patients	6 staff
Lewis 3	26.12.2021 – 09.01.2022	3 patients	0 staff
Lewis 2	28.12.2021 – 29.12.2021 02.01.2022 – 09.01.2022	0 patients 1 patient	4 staff 0 staff
Lewis 1	26.12.2021 – 29.12.2021 09.01.2022 - 18.01.2022	0 patients 1 patient	2 staff 0 staff
Arran 1	29.12.2021 - 31.12.2021	0 patients	2 staff
Mull 1	31.12.2021 (re-opened later that day)	0 patients	3 staff
Arran 2	13.01.2022 – 14.01.2022	0 patients	0 staff

QUALITY IMPROVEMENT

QI Forum

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

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

across TSH. The QI Forum meeting in January was canceled due to Covid restrictions and business from this meeting will be carried forward to the next scheduled meeting.

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

The six key themes of RM are:

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

The Learning into Practice session for January was cancelled due to Covid restrictions and business from this meeting will be carried forward to the next scheduled session.

The Programme Manager has established connections into the National Realistic Medicine Programme Managers group with the view to collaborate on any relevant projects under this work stream.

EVIDENCE FOR QUALITY

National and local evidence based guidelines and standards

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

Over a 12-month period, an average of 200 evidenced based guidance documents issued from a variety of recognised bodies can be reviewed for relevancy by the Clinical Quality Facilitator. During the period 1 November 2021 to 31 January 2022, 41 guidance documents have been reviewed. Six were recorded for information and awareness purposes and 3 are currently awaiting review by their allocated steering group for decision as to the need for an Evaluation Matrix – these were for the following:

TABLE 1 EVIDENCE REVIEWS

Body	Title	Steering Group
SIGN	Eating Disorders	MHPSG & PHSG
HIS	Sexual Heath Standards	PHSG
NICE	Heart valve disease presenting in adults: Investigation and management	PHSG

The remaining 31 documents were considered to be either not relevant to The State Hospital or were overridden by Scottish guidance.

TABLE 2 EVIDENCE REVIEWS

Body	Total No of documents reviewed	Documents for information	Evaluation Matrix required
SIGN	1	0	1 (as above)
Mental Welfare Commission	4	4	0
Healthcare Improvement Scotland (HIS)	3	2	1 (as above)
National Institute for Health & Care Excellence (NICE)	33	0	1 (as above)

As at the date of this report, there are currently 5 additional evaluation matrices which remain outstanding and await review by their allocated Steering Group. The progress of the first 2 evaluations from HIS and the MWC was temporarily paused due to The State Hospital adapting to the COVID-19 pandemic however as per Gold Command, action on matrix completion began again at the start of July 2020. The responsibility to review these matrices changed ownership from the PMVA Review Group to the Patient Safety Group which recommenced meetings in September 2020. Work is progressing with both. The Osteoporosis guidelines required input from the GP which has proven difficult to access. This evaluation matrix has now been completed and is tabled at the February PHSG for review. The review of the Public Health England guideline was unable to be completed within the tight deadline set by the Supporting Healthy Choices group due to poor attendance at the review meeting and delay in members submitting feedback responses. At the date of this report, a date for the next SHC meeting to review the document is still awaited. Although the Clinical Quality Department were approached to in order to complete an evaluation matrix for the remaining Kings Fund document entitled Courage of Compassion, this has now been placed on hold due to the retirement of the lead for this. This will be revisited once the new person is in post.

TABLE 3 GAP ANALYSIS SUMMARY

Body	Title	Allocated Steering Group	Current Situation	Publication Date
HIS	From Observation to Intervention: A proactive, responsive and personalised care and treatment framework for acutely unwell people in mental health care	MHPSG (via Patient Safety)	Evaluation matrix completed with 28 outstanding recommendations Patient Safety meeting took place mid-September. Evaluation matrix to be revisited upon creation of updated draft Clinical Engagement Policy.	January 2019
MWC	The use of seclusion	MHPSG (via Patient Safety)	Work ongoing. Release of updated Seclusion Policy currently on hold due to ongoing work with Clinical Engagement Policy currently being drafted with seclusion tier 1 and 2 being incorporated. Both to be launched together.	October 2019
SIGN	UPDATED: Management of Osteoporosis and the prevention of fragility fractures	PHSG	Evaluation matrix completed and will be reviewed at next PHSG meeting in February 2022	June 2020
PH England	Managing a healthy weight in adult secure services - Practice guidance	SHC	Unable to be completed within the tight deadline set by the Supporting Healthy Choices group due to poor attendance at the review meeting and delay in members submitting feedback responses. Awaiting next SHC meeting in order to take document forward.	February 2021
The Kings Fund	Courage of compassion – Supporting nurses and midwives to deliver high quality care	HR and Wellbeing Group	CQ were asked to assist in review of document in October 2021. Now on hold due to change in lead role (Dec 2021). Awaiting guidance once new post holder is in place.	September 2020

THE STATE HOSPITALS BOARD FOR SCOTLAND

Minutes of the Clinical Governance Committee Meeting held on Thursday 11 November 2021 at 9.45am via MS Teams CGC(M)21/04

CHAIR:

Non Executive Director	Cathy Fallon

PRESENT:

Non Executive Director	Stuart Currie
Non Executive Director	David McConnell

IN ATTENDANCE:

Skye Centre Manager	Jacqueline Garrity (part)
Social Work Team Manager	David Hamilton (part)
Chief Executive	Gary Jenkins
Consultant Forensic Psychiatrist	Khuram Khan
Head of Psychology	John Marshall
Board Chair	Brian Moore
PA to Medical & Associate Medical Directors	Jacqueline McDade
Director of Finance and e-Health	Robin McNaught
Head of Corporate Planning and Business Support	Monica Merson
Director of Nursing, AHPs and Operations	Mark Richards
Board Secretary	Margaret Smith
Head of Clinical Quality	Sheila Smith
Medical Director	Lindsay Thomson

1 APOLOGIES AND INTRODUCTORY REMARKS

Cathy Fallon welcomed those present to the meeting.

2 CONFLICTS OF INTEREST

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

3 TO APPROVE THE MINUTES / ACTON NOTE OF PREVIOUS MEETING HELD ON 12 AUGUST 2021

The Minutes of the previous meeting held on 12 August 2021 were approved as an accurate record.

4 PROGRESS ON ACTION NOTES

CAT 1 20/03

Margaret Smith advised that learning from adverse incidents to ensure non-executives have an understanding of what is going on was due to go to the Board Seminar session in September but, due to time contraints, this will be taken to a future session.

5 MATTERS ARISING

There were no matters arising at this time.

6 PHYSICAL HEALTH STEERING GROUP 12 MONTHLY REPORT

The Committee **received** and **noted** the Physical Health Steering Group 12 monthly report, which was summarised by Khuram Khan, Chair of the Physical Health Steering Group.

Khuram Khan described the core activity during the past 12 months, which includes activities within the Health Centre: flu vaccination clinics, Colorectal Screening, Abdominal Aortic Aneurysm Screening, Cardiovascular Risk Assessment, Urinalysis Screen, covid vaccinations, type 1 and type 2 diabetes checks, including foot reviews, respiratory diseases, Asthma and COPD, Unscheduled/Emergency Clinical Outings, NHS24/Out of Hours/Urgent Care, Dental Service, and podiatry.

The "Near Me" web based platform was used during the reporting period for physiotherapy clinics and external services. Face to face consultations have resumed for clinics by Advanced Nurse Practitioners and GPs.

The report contains narrative around Food, Fluid and Nutrition (FFN) and Food in Hospitals (FiH), a highlight of which has been the counter weight programme which continues to be successful.

Comparison with Last Year's Planned QA/QI Activity
There were 6 objectives set; 3 of these have been completed – counter weight, health and wellbeing plans and the amalgamation of the Healthy Living Group and Healthy Eating Group.

The other 3 objectives have not yet been completed.

Health Improvement events were postponed due to the restrictions in place related to COVID19. These are being reintroduced over the coming months in line with the remobilisation plan.

Short life project to explore supervised patient access to the internet for purchasing non-food items should be set up. Pilot has commenced in Arran 1, Equipment has been installed on the ward. This work has moved to the digital inclusion agenda.

Continue to develop, supporting and monitoring the Supporting Healthy Choices agenda - A new Supporting Healthy Choices Plan (SHC) has gone to the board and will be actioned under a separate remit. A new post will be advertised for Supporting Healthy Choices (SHC) Project Manager. Following the appointment of a SHC Project Manager, a SHC implementation group will be formed to implement the SHC Plan 2021/22.

Key Performance Indicators
90% of patients will be offered an annual physical health review - Achievement has dropped due to review and ongoing work to correctly reflect the uptake and quality of the physical health care provided as per the Annual Health Review. GP visits on a monthly basis to review patients in person; we also have Advanced Nurse Practitioners who provide weekly sessions.

Target of 80% of patients will undertake 90 minutes of moderate exercise each week – Target has been achieved from April to September 2021 at highest levels recorded. This target is going to increase to 150 minutes of exercise for 80% of patients.

25% reduction in the number of patients with a BMI over 40 and a further 5% reduction in the number of patients with a BMI over 30. - This remains an issue at the moment. Patients in the "healthier" category dipped to a low of 7% however have increased in June to September to 11%.

100% of patients requiring primary care services will have access within 48 hours - The Hospital is currently meeting the target of 100%.

Quality Assurance Activity
A number of audits have been completed or are ongoing, with recommendations being made.

Physical Health Monitoring Equipment Audit - a short life working group has been set up to look at the various recommendations. This will be discussed at the next Physical Health Steering Group, with an action plan being drawn up to take things forward.

National and local evidence based guidelines and standards
Over the review period 51 guidelines/standards reviewed by the Physical Health Steering Group. 44 were deemed to be either not relevant or were covered by a similar guideline. Of the remaining 7 guidelines / standards, 4 of these publications had varying degrees of relevancy to physical health services within The State Hospital and were sent out for information purposes. There were Evaluation Matrices conducted for 2 of the 3 remaining guidelines / standards whilst a decision is currently pending regarding the 1 remaining document.

Quality Improvement activity
Patient Sports Volunteer Roles – work is ongoing at the moment. In process of making a plan to utilise the activity co-ordinators to liaise more effectively with hub staff.

Health Passport – funding options are being explored to take this forward.

Trainee Health Psychologist – undertaking research project within the Hospital to understand the barriers of physical activity. The findings of the research will be presented in February 2022.

Planned Quality Improvement activities for next year

- Look at Physical Health data pre and post Covid and ways that we can use this data to establish a "new normal".
- Continue to monitor patient's physical activity and review what effect the "re-opening and new normal" will have on patient's physical activity levels by completing 6 monthly physical activity.
- Continue to monitor the timescales in when patients Sports induction are completed under a "new normal".
- Supporting key dietary messages, to promote good nutritional care and healthy eating within the restrictions of a current pandemic.
- Consultancy project within TSH regarding patient's weight loss maintenance – 'To investigate patients perceived barriers and facilitators to weight loss maintenance.'

David McConnell stated that it was good to hear that the healthy living group was recommencing and asked if this would be in an in-person format or if there were virtual options within the Hospital. He also stated that there were a number of "to be confirmed" within appendix 2 and asked if these could be fleshed out in due course.

Khuram Khan advised that his understanding was that the group would be in-person from next year. With regards to appendix 2, he will look into this and add more detail within the next report.

Brian Moore stated that there were a lot of positive initiatives within the report. He sought clarification in relation to the proposal for the Health Psychologist post which was coming to an end and the recommendation that we should have that post. He was unclear on the issue of Synbiotix and if there was a decision to be made to use that organisation or system. He went on to say that, as with all reports, there is so much information but some headline figures jump out, such as 86% of patients are overweight or obese and we need to make every endeavour to work together to get the figure changed over time.

Lindsay Thomson advised that the Clinical Governance Group had asked for the supporting healthy choices strategy and measurement strategy to be added to the report for next year as this is a major priority for us. Khuram Khan advised that the report will be amended and the information will be included.

Action: Khuram Khan

John Marshall advised that NES had provided partial funding for the Health Psychologist post over many years but we had not been successful this year. This would be an additional post which would require additional funding. Mark Richards advised that this is important for us as a hospital going forward and this needs to be looked at in terms of workforce planning and defining what is possible on that. One or two fully trained health psychologists are included in the Supporting Healthy Choices Plan and funding for this will be explored by Mark Richards and John Marshall.

Action: Mark Richards / John Marshall

Mark Richards also advised that Synbiotix is a national platform linked to catering standards and we will be required to adopt that in the future; this will help with nutritional analysis and meal planning. There is no date yet for when this will be implemented.

Monica Merson stated that she was interested to hear of the increased target from 90 to 150 minutes of activity and will discuss with Khuram Khan outwith the meeting regarding date of change, what data will look like and the plan to take forward. She suggested we complete this year with the 90 minute target and move to increased target from quarter 1.

Lindsay Thomson advised that, within the Health Centre, she would like to have the GP attend more frequently, however, due to sickness absence within the GP practice, we have support from Advanced Nurse Practitioners with the GP providing one session per month in person; they also provide telephone advice. We are unable to go to another practice as across the board services are stretched. The Physical Health Steering Group have shown the range of work they do and what is provided to patients in terms of screening and the services available to them is the priority on physical health care and the supporting healthy choices agenda.

Cathy Fallon stated that there is a lot of work coming out of this and she looks forward to hearing about the discussions between Khuram Khan and Monica Merson; also hearing more from John Marshall in relation to the health psychologist post.

The Committee noted the report.

7 PATIENT MOVEMENT STATISTICAL REPORT

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

There have been 13 admissions and 10 discharges since 1 April 2021. All bar one admission was within the 6 week target; the one outwith was due to court delay.

There are 10 patients on the transfer list; 13 were fully accepted and ready to transfer.

We currently have 117 patients, 2 of whom were admitted under exceptional circumstances. Due to tight bed position we have a bed contingency plan, the final version of which will be presented to the Corporate Management Team; the content of the plan has been fully agreed.

Brian Moore stated that this was a helpful report in terms of the detail of admissions and discharges and asked what the time period is to unblock delays for the 13 patients who have been assessed and transfer agreed.

Lindsay Thomson advised that the Network had developed short, medium and long term plans for the Scottish Government. This generated 10 beds and we have now been asked to take this forward and discuss whether we have weekly bed meetings. This will go to the Inter Regional Group on Friday for agreement; it is envisaged that this will be established together with a short term short life working group for the Barron report.

Gary Jenkins advised that he has established fortnightly meetings with colleagues in Glasgow to discuss the transfer list; this ties in with the work being undertaken through the Forensic Network.

The Committee noted the report.

David Hamilton joined the meeting at this time.

8 CPA / MAPPA 12 MONTHLY REPORT

Cathy Fallon took the opportunity to congratulate David Hamilton on his substantive post to Head of Social Work.

The Committee **received** and **noted** the CPA / MAPPA 12 monthly report, presented by David Hamilton, Head of Social Work.

Lindsay Thomson advised the Committee that the CPA is a mechanism by which we programme the care with and for our patients on an individual basis; there are different types of CPA – annual and intermediate; but here we are dealing with transfer and discharge CPA.

CPA
100% target of CPA meetings for patients moving on was met during reporting period.

There were 32 transfers and discharges during the reporting period, again, the target was met. There was an increase of 9 patients being transferred compared to the previous reporting period

Consideration was given to the Early Discharge Protocol on 2 occasions during this review period. However, the EDP did not require to be invoked due to robust contingency planning having taken place on both occasions.

73% of patients attended their CPA meeting; this is a decrease of 4% on the previous reporting period. This is an area where we need to get a better understanding and to tease out why we are not getting patient attendance.

Carer attendance has increased slightly as a result of the work being done to enable carers to attend meetings virtually. We are currently seeing around a 50% attendance rate.

During the reporting period, a total of 21 Patient Experience Feedback forms were sent out. Only 4 forms were returned and although these indicated a general level of satisfaction with the CPA process, it is difficult to form a clear picture with these figures.

MAPPA Activity
The State Hospital has continued to meet its responsibilities in relation to MAPPA in the reporting period.

Notifications are required to be made immediately on admission for restricted patients . A total of 38 patients were admitted to The State Hospital during the reporting period – an increase of 2 from the previous year. 20 of those patients admitted were restricted upon admission and notifications provided to MAPPA in all cases.

Community Justice Authorities (CJAs) have also been notified of all patients whose status changed and who subsequently became restricted patients during the reporting year.

The purpose of a MAPPA referral is to ensure that there is an opportunity for full multi-agency consideration of public and victim safety issues. This normally occurs when a patient is either being considered for a move to a non-secure environment or is discharged to the community. The potential exists for a MAPPA meeting to be convened to consider the public safety and victim issues which may arise from a patient outing for clinical, rehabilitation or compassionate reasons.

One MAPPA Level 2 Meeting was convened during the reporting period in response to a situation where there was felt to be a risk of a patient returning to the community. This meeting was well attended by staff from The State Hospital and community partners and was raised as an example of good practice at the Lanarkshire MAPPA Operational Group.

During the review period no patients have been identified as potentially meeting the 'risk of serious harm' category as defined by Section 10(1)(e) of the Management of Offenders etc (Scotland) Act 2005. However, all patients remain under consideration in this regard and consultation takes place with the relevant MAPPA Co-ordinators as appropriate.

Progress from last Annual Report
Carer involvement - There is evidence of improvement in the past 12 months however continued efforts are required to promote this.

MAPPA training - An appropriate training template has been identified and is to be adapted to be relevant to the needs of State Hospital Staff before being uploaded to Learnpro.

CPA Processes and Paperwork to be reviewed to support a person centred and inclusive approach - The Mental Health Practice Steering Group has undertaken considerable work in this respect and will report directly to the Clinical Governance Group on developments in due course.

MAPPA policy and DPIA to be developed for The State Hospital – discussions have taken place with the Hospital's Information Governance Officer around MAPPA information sharing and agreements are progressing with partner agencies. A brief stand alone policy will be required within the Hospital.

Future areas of work

- Stakeholder Feedback methods to be reviewed
- MAPPA Policy and DPIA to be concluded
- MHPSG to report on progress in relation to CPA Processes and Paperwork to CGG
- MAPPA Training materials to be reviewed and uploaded to Learnpro
- Data analysis in respect of Carer Involvement will be reviewed

Brian Moore stated that this was a comprehensive and positive report and that the Barron Report made reference to CPA and he thinks that we are compliant with the issues raised; it is important to emphasise that in terms of overall reporting in this area.

Cathy Fallon thanked David Hamilton for this comprehensive report and stated that she was looking forward to further reporting on analysis of care involvement, Learnpro training and information sharing within the Hospital.

The Committee noted the report.

9 ADULT & CHILD PROTECTION 12 MONTHLY REPORT

The Committee **received** and **noted** the Adult & Child Protection 12 monthly report, presented by David Hamilton, Head of Social Work.

David Hamilton advised that the Child & Adult Protection forum meets on a 6 weekly basis and is chaired by Mark Richards.

Core Activity

- For those patients who are parents, 4 have some form of contact with their child. 24 patients are authorised to have some form of child contact

- There were 7 child visits to the hospital during the reporting period which is a significant decrease in numbers in comparison to the previous reporting period. This is largely due to infection control measures as a result of Covid; the impact of this was mitigated by the use of video visits.
- 14 child contact applications were received during the reporting period.
- 15 children were removed from the list as a result of patient transfers or a transition to adult visiting.
- 61 children were approved to have some form of contact with a State Hospital patient. This is a decrease of 13 when compared to the last reporting year.
- Child visitors are routinely supported to make the transition to adult visitors. However, where it is in their best interests they may continue to be supported as child visitors beyond the age of 16 years.
- No patients under the age of 18 years were admitted to the hospital in the reporting period.
- 10 Adult Protection inquiries were undertaken during the reporting period. This is a slight reduction from the previous year.. An increase in activity has been noted following the cessation of Covid related ward restrictions and increased patient mixing.
- Of the 10 inquiries undertaken, 4 related to a single patient.
- The main source of harm noted was patient/patient interactions which accounted for 8 inquiries, with 3 referrals relating to patient/staff interactions.
- The main categories of harm noted were psychological (6) and physical (3). Patient / patient interactions accounted for 8 inquiries with 2 referrals related to patient / staff interactions.
- The breakdown of inquiries by hub is as follows: Iona, 4, Mull, 1, Arran, 4 and Lewis, 1.
- There is evidence of clinical staff working in a pro-active manner to avert risk and maintain patient safety.
- Ongoing education and awareness sessions for staff continue to be of key importance.
- Similar to Child Protection, positive and productive links with South Lanarkshire Council's Adult Protection Committee have been established. This takes the form of:
  - Attendance at the Adult Protection Committee by the Director of Nursing and AHPs/Mental Health Manager.
  - Support with the review and endorsement of our local policy and procedure.
  - Support for our training initiative.
  - Attendance at pan-Lanarkshire seminars on Adult Protection.
  - Providing our local KPIs on referrals to provide pan-Lanarkshire statistics and comparisons.
  - Contribution to the SLC Annual Report on Adult Protection.

Training

- The level 1 and level 2 e-learning modules on Learnpro for Keeping Children Safe training and Adult Support and Protection are now well established, with a 2 year refresher requirement for level 2.
- Half day Workshop sessions on Keeping Children Safe and Adult Support and Protection continue to be rolled out across the hospital and are currently facilitated by the social work service with support from both nursing and Learning Centre staff.

For all new nursing staff, ½ day briefing sessions are incorporated into the induction plan. Input into these sessions has continued in collaboration with the Nursing Practice Development team.

Key Performance Indicators

- 200 Child Protection Summaries were completed in relation to 202 CPA meetings which took place achieving compliance of 99%.
- Adult Support and Protection inquiries to be completed within 5 working days – achieved in 80% of cases. 2 inquiries were extended to take account of the circumstances and needs of the patient involved.
- Training – ASP level 2 - 100% Target completion rate for target group. 78% achieved. Measures are in place to get this back on track.

Quality Improvement

The Adult Support and Protection Policy and Guidance has been reviewed and updated to take account of national developments and shared learning.

Keeping Children Safe policy is being reviewed and it is hoped that this will be completed by January.

Corporate parenting plan has been submitted to the Scottish Government.

Training materials have continued to be updated and developed to ensure they provide up to date information and practice guidance.

A member of the Social Work team has been supported to commence the Post Graduate Certificate in Adult Support and Protection with the aim of improving expertise within The State Hospital.

The Social Work Team Leader has offered to provide additional training slots and development sessions to staff who may find it difficult to attend the regularly scheduled inputs.

Stakeholder Feedback
The majority of families are pleased with the support they receive; one family felt that the policy and processes around child contact was overly intrusive and withdrew from the process.

All patients involved in adult support and protection issues are offered access to the Advocacy Service. Staff have also engaged with speech and language services for support for patients with communication needs and the use of Talking Mats to try and get involvement and participation.

Planned Quality Assurance/Quality Improvement for the next year
It is hoped that the Keeping Children Safe policy will be completed by January 2022.

Roll out of level 2 training dates and improve on attendance.

Stuart Currie commented on the drop in the number of child visits and asked whether we anticipate they will return to a level we would expect and, if so, when would that likely happen.

David Hamilton advised that levels dropping coincided with schools going back; hopefully by Christmas we will see if there is an uptake in visits. Feedback from one family in relation to video visiting was that this was seen as a stepping stone and gives more flexibility.

Mark Richards advised that Covid had an impact on the appetite to travel and come into our setting; a benefit of this was the development of a digital platform and we have made good progress with that in terms of connecting with families and offering a blended approach. A review is currently being undertaken, which is due to report at the end of the month which will set out the proposed visiting model going forward within the hospital.

David McConnell sought some further information in relation to what is done or what is planned for defining and capturing near misses in terms of child and adult protection.

David Hamilton advised that near misses would be recorded through Datix and alerted at an early stage and are scrutinised through the Child & Adult Protection Forum, where this is a standing agenda item; we need to define what is a near miss and how we record that. There were no issues over the last 12 months.

The Committee noted the report.

David Hamilton left the meeting at this time.

10 COVID-19 REPORT

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

As discussed at the previous CGC, this is a much reduced report from those presented previously. Appendix A listed all headings from previous reports. The plan for next year as we move towards living with Covid is that this will come into the Infection Control report rather than being a stand alone agenda item.

Outbreaks
During August and September there were 6 positive cases identified within 2 wards. This affected 2 patients in Mull 1 and 4 patients in Iona 3. 2 of the patients from Iona 3 required care in University Hospital Wishaw; both recovered and were transferred back to the Hospital. A Problem Assessment Group was set up in response to the two outbreaks to manage the initial response; and this was followed by Incident Management Team meetings. This included senior colleagues from the national ARHAI Team, the Infection Control Consultant from NHS Lanarkshire as well as colleagues from NHS Lanarkshire Test and Protect. These incidents were successfully managed through this process with no further spread in the Hospital beyond these cases.

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

A mobile testing unit was brought on site on Thursday 14 October 2021 to carry out mass PCR testing for staff identified as contacts of positive cases as well as for staff who may have been concerned. Members of staff who returned a negative PCR were advised to continue to carry out daily Lateral Flow Device testing for a period of ten days from their test date.

Patient Flow
There have been 5 Admissions over the period of 1 August 2021 to 31 October 2021. There have been 3 discharges during this period.

Operational Model Monitoring Group
The work of the OMMG continues. Issues highlighted have been staffing levels and access to fresh air due to reduced daylight and poorer weather.

General Medical Ward
Due to the rise in Covid-19 cases in August and September 2021, CMT asked for information on requirements and timescale to reopen the State Hospital medical ward. The ward would only be used if beds in general hospitals were not available. It would take between 2-4 weeks to open the ward if required however, the main issue is the advance in medical treatments for C-19 and whether these could be safely delivered within the State Hospital. This is currently being explored with colleagues at University Hospital Wishaw.

Scientific and Technical Advisory Group
The Scientific and Technical Advisory Group has been stood down with different mechanisms put in place to ensure that the role is not lost. The main surveillance report goes to the fortnightly Corporate Management Team; the Infection Control Committee meets monthly and we have membership at the NHS Lanarkshire Horizon Scanning Group.

Appendix B provides information on patient test numbers, vaccinations and boosters, staff test results, absence rates and vaccinations which are reported to the fortnightly Corporate Management Team.

It was noted that lateral flow test recording is a major issue across the whole of Scotland with a

14% national recording rate.

Modelling data is also reported; this is very important to keep us as up to date as we can be on the national position. Currently the R rate is between 0.8 and 1.

Hospital and ICU occupancies are in a plateau. There continues to be uncertainty over hospital occupancy and intensive care. General beds in use for C-19 are about 950 – within expected range. ICU beds in use about 80 – within expected range at lower end.

The Committee noted the new format of the report and its usefulness.

Jacqueline Garrity joined the meeting at this time.

11 REHABILITATION THERAPIES 12 MONTHLY REPORT

The Committee **received** and **noted** the Rehabilitation Therapies 12 monthly report, summarised by Jacqueline Garrity, Skye Centre Manager.

Mark Richards advised that this is the first report to the Committee focussing on rehabilitation therapies. Historically there has been a focus on AHP and Skye Centre reporting separately but it was agreed to bring these together into a single report and we would welcome feedback from the Committee if this is what they are looking for.

Jacqueline Garrity advised that the report provides an overview of activities provided over the past year, with all disciplines supporting the delivery of activity during the reporting period. There has been a difference in how services have been delivered in terms of the patient timetable with shorter sessions or a mixture of sessions provided since the reintroduction of the timetable in June 2021.

Occupational Therapy staff have been able to recommence assessment activities using the Assessment of Motor and Process Skills (AMPS) tool. 58 AMPS were carried out; 47 of which were carried out since May 2020.

Jacqueline Garrity sought the views of the Committee on the format of the report and what other data they would like included.

David McConnell asked for clarity in relation to MOHOST assessments and the difference between information contained within tables 1 and 4.

Jacqueline Garrity advised that the MOHOST is part of the ICP and an initial assessment for new patients but it is also used for ongoing assessment. The Occupational Therapist for the Skye Centre focussed on using a MOHOST to get a baseline for patients attending the Skye Centre during 2019/20. Thereafter they were not engaged in day to day routine as they contributed to wider group activities within the Hospital. Each ward and hubs have OT engagement in the admission process so assessments should all be carried out within timescales for new admissions.

Brian Moore noted the ongoing work on skills mix and 7 day service and found the report very helpful. Future reports should be about understanding and seeing how it works on a whole system approach.

Lindsay Thomson stated that we are endeavouring to have a suite of reports around the patient as an individual or as a group. We have physical health report, psychological therapies report, medicines report, education report and rehabilitation. Over the last 18 months due to Covid we have had to change the clinical model which became more restrictive. In response to this all activity was measured. We are now becoming more sophisticated as we measure specific rehabilitation activities and not just the quantity; we need a meaningful matrix of figures we can follow and compare year on year. This also concerns quality and meeting patient needs and

outcomes. There is a piece of work ongoing on how we are meeting these needs. This is what we specifically need to see in the months to come.

Lindsay Thomson asked if the activity co-ordinators have made a difference or if, due to Covid and staffing difficulties, this has prevented them from making a difference.

Jacqueline Garrity advised that they have made a difference, particularly for patients at ward and hub level and it is about building on that; they have been utilised at ward level due to staffing deficits to support ward staff to engage patients in activity in the ward or hub. We are looking at how we can demonstrate the impact of that and look at the benefits and impact for patients.

Jacqueline Garrity also advised that she had looked at previous recommendations from the last report and had had a discussion with the Lead OT as there was an action for taking forward AMPS and a TSH3030 project which had not been taken forward. Hannah Connor is now taking this forward and information will be fed into the next report.

Mark Richards stated that he would wish to see what we assessed, what did we plan to do to deliver care and treatment, what did we actively deliver and what was the outcome. We need to get more sophisticated around that for the next report and the MOHOST and AMPS will feed into the reporting. With regards to activity co-ordinators, there is a trendline showing a slow but steady increase in engagement with patients; this also addresses issues patients have been highlighting around 7 day a week activity not just Monday to Friday 9-5.

Mark Richards informed the committee of a quality improvement project, which is being led by Dr Gordon Skilling and Lindsay Tulloch looking at activity within the Hospital and the comprehensive process map that has been produced; the next stage will be to generate change ideas activity integration between wards, hubs and the Skye Centre.

Cathy Fallon expressed her thanks to staff groups and commended them on how they have adapted to new ways of working and congratulated craft and design for their award. She looks forward to the next report which will include a whole system approach and learning from a patient perspective.

The Committee noted the report.

Jacqueline Garrity left the meeting at this time.

12 LEARNING FROM FEEDBACK

Members **received** and **noted** the Learning from Complaints Report presented by Mark Richards, Director of Nursing, AHPs & Operations.

The Patient Partnership Group has been fully re-established with all wards engaging. Some issues being looked at include digital inclusion, supporting healthy choices and clinical service delivery model.

There have been 82 pieces of feedback over the last quarter, with the largest single theme relating to effective relationships. There is also positive feedback relating to visiting around the family centre.

There were 10 compliments received, including reinstatment of the Patient Partnership Group, efforts around access to activity, work security colleagues are doing to mitigate the impact of work in the grounds and spiritual and pastoral care services being reinstated which was very welcomed by the patients.

31 concerns were raised; the majority of these relate to challenges around access to activity, which is a consequence of staff availability and inconsistencies of staff at ward level which is being addressed by Lead Nurses engaging with Senior Charge Nurses.

Appendix 1 covers output from the "What Matters to You" exercise.

David McConnell asked if there was any concern in the rise in numbers in respect of effective relationships from 1 to 14 in table 1.

Mark Richards advised that table 5 sets out the concerns and this links back to inconsistencies across lines of staff and patients having a different experience depending on who is in charge of the ward, for example, one member of staff may allow hot drinks in the patient's room but the next person does not. This is being taken back through the Lead Nurse structure and Senior Charge Nurses emphasizing the importance of consistency across shifts rather than individual preference.

Brian Moore stated that he enjoyed reading the report and referred to catering staff and how their support was appreciated and he hopes that this was fed back to staff.

Stuart Currie was pleased to note that the reinstatement of the Patient Partnership Group makes a big difference.

Mark Richards advised that it is essential that we have a functioning Patient Partnership Group, bringing patients together face to face. We do have service delivery challenges and it is working with patients to understand that and get is a better understanding around issues we have.

Margaret Smith has been invited to attend a meeting and is in contact with Sandie Dickson on how to do that; this is likely to be in January. Gary Jenkins will be attending in the next couple of weeks to have a discussion on some correspondence he has received.

Cathy Fallow advised that point 7 in table 5 should be morale and not morals. She also asked for some clarity on point 10, the impact of sports equipment.

Mark Richards advised that we were introducing a programme of equipment replacement within the Skye Centre and there was a bit of disconnect between what people were seeing in the catalogue versus the exact suitability for the specific environment; this has now been sorted out and lessons learned in terms of how we are involving the right people at the right point in time in purchasing equipment for use within a high secure environment.

The Committee noted the report.

13 LEARNING FROM COMPLAINTS

The Committee **received** and **noted** the Learning from Complaints report, presented by Margaret Smith, Board Secretary.

The report provides the Clinical Governance Committee with an overview of activity of complaints, concerns and enquiries for the second quarter of the financial year 2021/22. The report shows the complaints received, the stages at which they were handled, as well as complaints closed within this time period.

During the reporting period, there were 21 new complaints received and 17 complaints were closed. 14 of the complaints received were resolved at Stage 1 of the complaints handling process, 13 of which were closed within the 5 day target response time.

Nursing and Security Management teams are working to ensure the impact of staff shortages and the security refresh project are minimal.

The Patients Advocacy Service (PAS) which is an independent service within the Hospital, provided support to patients in 16 of these cases. Complaints staff link in with PAS to discuss complaints handling and how to support patients to ensure that they can access the complaints service

Complaints Experience Feedback
Due to the low numbers of complaints, and often the same patients complaining over time about different issues they are repeatedly asked for feedback when they have already provided this so there seems to be a bit of patient fatigue around being asked for feedback. The Complaints Officer continues to try and promote this to patients to encourage them.

Stuart Currie asked about confidence in the system if nothing is upheld and if we get feedback about this from a patient or staffing point of view.

Margaret Smith replied that, as far as patients are concerned, the Complaints Officer regularly meets patients, she will ask how their complaint has been resolved or feedback from PAS, it does help confidence in the system, even if there is no immediate solution, they do feel heard. Because they have made a complaint they have assurance we are trying to put actions in place. Gary Jenkins is attending the Patient Partnership Group as a result of concerns coming forward and the need for us to be transparent and show them we are listening to them and are doing our best. With regards to staff, we are trying to develop a confidence among staff to say yes; there has been a reluctance in the past to be transparent and it is good to acknowledge where things went wrong in the first place before putting in a solution.

Lindsay Thomson stated that there is a clear and established process where patients can raise issues and we would support them to do that and we look at outcomes of that.

Mark Richards advised that we see outcomes through the Learning from Feedback and Learning from Complaints reports and, as an organisation, we are good about offering detailed explanations to patients or carers who raise concerns or formal complaints. It is really important people understand why things happened in the way they have and it is important we acknowledge when they get things right. Mark Richards suggested asking the Patient Partnership Group about the level of confidence in our processes and he will pick this up with Sandie Dickson.

Action: Mark Richards

Cathy Fallon thanked Margaret Smith for the report and stated that it was good to see targets for closure and how staff have tried to resolve issues at an early level; she looks forward to receiving feedback from Mark Richards on the issue of confidence in the process.

The report was noted by the Committee.

14 INCIDENT REPORTING AND PATIENT RESTRICTIONS

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

- PAA activations have increased from the previous quarter. During July there was 10 activations. This included 5 activations in Iona 1. 3 activations in Iona 2. During August there was 7 activations in Lewis 1 (1 patient newly admitted), Lewis 2 and Arran . The activations decreased to 4 in September
- Patients are given the choice to provide a sample of either urinalysis or oral fluid test; the majority of the patients opt to use the oral fluid test.
- Handcuffs were used on 7 occasions during the quarter when patients were attending clinical appointments. One patient was escorted in handcuffs but once admitted to University Hospital Wishaw SRK's were used.

- On admission a patient was found to have a bag of vapes hidden in his groin.
- A vape cartridge was found in a patient's room. The patient had recently been admitted from prison.

General Incidents

- 460 incidents were reported on Datix, a significant increase from 243 incidents reported in the previous quarter, all have been finally approved.
- In July there were 156 incidents, the highest total since April 2019, these numbers have continued with 154 and 150 in August and September respectively.
- 235 of these incidents were reported as staff resource issues, accounting for more than half of the total incident figures.
- There were 8 'Very High' incidents reported in this period, up from 0 in the previous quarter. All 8 of these incidents involved staffing issues, specifically relating to the closure of wards.
- There were 141 'High' incidents reported in this period, up from 0 reported in the previous quarter.
- 9 incidents were reported under Communication/Information Governance. The 'High' rating comes from an increased frequency of incidents reported under this category involving emails containing confidential information being sent to the wrong individual/department.
- 132 incidents were reported under Staff Resource Issue. The 'High' rating comes from an increased frequency of reporting staffing issues across the hospital and an increase in the impact that these issues are causing the hospital and its patients.

Health and Safety Incidents

- 115 incidents reported related to health and safety, an increase of 21 on the previous quarter.
- 'Behaviour' had the highest number of incidents in the H&S category at 42; this is an increase of 6 from the 36 incidents reported in the previous quarter. 31 incidents were recorded as "Threatening/Intimidating Behaviour" 8 as "Other" and 2 as "Destructive.
- 'Verbal Aggression/Abuse' more than doubled to 22 incidents in Q2 up from 10. 14 were 'patient to staff' 6 'patient to patient' and 1 'carer to staff.
- 'Assault' increased from 2 to 6. 1 incident resulted in an over 7 day absence and was RIDDOR reportable to HSE. 4 incidents were 'patient to staff' and 2 were 'patient to patient'.
- 'Staff/Patient Injury' increased from 3 to 8 in Q2. 5 were from patients injuring themselves during football, staff member injuring themselves during badminton, PMVA injury and patient stubbing toe on door.
- 'Attempted Assault' remained similar at 12. 11 incidents were recorded as 'patient to staff' and 1 'patient to patient' Incidents came from a varied number of wards and patients.
- 'Slip/Trip/Fall – Patient' incidents remained similar at 13. Incidents mainly involved patients tripping up, losing their footing or slipping on shower/gym equipment.
- Incidents numbers generally increasing or remaining the same, only major decrease was 'Sexual' incidents down from 8 to 1 compared to last quarter.
- No patients on the Assault Tracker.
- One seclusion was recorded over the quarter. This is a decrease from 3 in the previous quarter.

Staff Resource Incidents

- 235 incidents were recorded during this period, showing an increase of 169 on the previous quarter.
- 132 incidents had a 'High' rating and 8 'Very High' as mentioned previously.
- Incidents reported have been highlighting issues such as:
  - Being unable to meet the required number of nursing staff onsite
  - Being unable to fully cover responder model
  - Running with less than agreed DRN numbers
  - Staff members not turning up for overtime due to miscommunication

- Lone working, unable to provide proper care
- Ward closures

Security

- **29** incidents were recorded during this period, similar to previous quarter.
- 'Breaches' decreased from 12 to 6 in this quarter. The incidents reported included disassociation rules not being adhered to, missing DVD from library, server room door being left open, GEO Amey vehicle being left unattended with door open and mail policy not being followed.
- 'Prohibited or Restricted Items' increased to 11 in Q2, incidents involved items found within rooms/wards (vape cartridge, crepe bandage), items found on grounds (metal object x 2, aluminium can), contractors found to have alcohol in vehicle, prohibited items being sent in by family members (aerosol cans, protein bars) and item being left over from music therapy session.
- 'Substances' remained similar at 2. Incidents involved sightings of apparent "hallucinogenic" mushrooms on hospital grounds and patient swallowing an unknown substance.

Infection Control

- 10 incidents were recorded during Q1, the same as the previous quarter.
- Patient suspected contagious illness increased from 2 to 4, incidents involved patients experiencing vomiting and loose stools.

Direct Patient Care

- 31 incidents were recorded during this period, up from 22 in the previous quarter.
- 'Self-Harming Behaviour' increased from 14 to 18: 4 different patients were reported as having self-harmed in this quarter up from 4 in Q1. 8 occurred in Mull 1 from 1 patient, 7 from 1 patient in Iona 2, 2 from another patient in Iona 2 and 1 from a patient in Arran 1.
- No new patients on Self Harm tracker, 2 remain.
- 'Medicine Administration' Incidents remained similar in Q3 at 3. Incidents involved patient not receiving prescribed medication due to communication issue, patient not receiving prescribed depot injection on due date and secreted tablet found.
- 'Medication Other' included medicines being found in pharmacy outwith procedural storage and shortage of Sertraline on wards despite medication being delivered 3 days prior, whereabouts unaccounted for.
- 'Patient Physically Unwell' increased from 0 to 7 in Q2. Incidents involved choking (3), unwell whilst being diagnosed with covid-19 (2), patient becoming unwell and requiring ambulance to WGH and patient experiencing seizure like symptoms after anaesthetic.

Equipment, Facilities and Property

- 18 incidents were recorded during this period, similar to the previous quarter.
- 'Equipment Malfunctions' increased slightly from 6 to 9.. The incidents involved PAA failure/issues (4), speaker/call system error, pager fault, compound gate fault, electrical system fault and pool table fault.
- 'Service' Incident was due IT outage across the site.

Communication/Information Governance

- 18 incidents were recorded during this quarter, an increase of 11 on the previous quarter.
- The 'Breach of Staff Confidentiality' incidents increased to 7, most incidents involved email containing personal information being sent to wrong address. 5 of these have been graded 'High' due to frequency this is occurring.
- 'Breach of Patient Confidentiality' decreased to 1 in Q1. Incidents involved patient details being sent wrong email address, graded 'High' due to frequency.
- 'Media Article' Involved a potential leak to local paper, graded as 'High'
- 'Documentation' increased from 1 to 5. 4 incidents involved late submitted Leavers forms and 1 involved missing file when preparing info for SAR.

- 'Other' Incidents remained the same at 2. Incidents involved calls being made to wards looking for information and new starts information being sent to wrong email address, graded 'High'.

Brian Moore stated that staffing shortages is a recurring theme and it may be good for the Committee to get an update on the day to day issues as it impacts on the overall health within the Hospital, particularly in relation to patient and staff safety.

Mark Richards advised that the Staffing and Care Report (agenda item 16) sets out the staffing challenges, the consequences of staffing and the impact on patients. The Operating Model Monitoring Group (OMMG) meets fortnightly and includes clinical leads from each of the hubs and looks at data across the weeks in relation to staffing, access to fresh air, access to physical activity. This will be covered later in the agenda.

Gary Jenkins advised that there is a distinct number of staff needed and there are a number of measures being taken forward around supplementary staffing and a possible nurse bank.

David McConnell suggested staffing be included as an area of concern for the Committee to keep an eye on.

15 DUTY OF CANDOUR 12 MONTHLY REPORT

Members **received** and **noted** the Duty of Candour 12 monthly report, presented by Lindsay Thomson, Medical Director.

Lindsay Thomson advised the Committee that Duty of Candour is a national requirement with reports being submitted to the Scottish Government. The report sets out the Duty of Candour procedure and the threshold for this.

97% of eligible staff have completed an e-learning module.

The Duty of Candour group meets monthly and looks at Datix reports, referrals, etc. This year 63 incidents were considered by the Group, up from 43 in the previous year. None of the incidents met the Duty of Candour threshold. Since the commencement of Duty of Candour there has only been one incident that met the threshold.

During recent months we have been dealing with complex issues in relation to Covid-19 and hospital acquired infections and the Group looked at advice from the Central Legal Office as to where this was set.

David McConnell highlighted an error with dates on page 6 which were a year out. Lindsay Thomson apologised for this and advised that the dates would be corrected.

Action: Lindsay Thomson

The Committee noted the report.

16 STAFFING & CARE REPORT

Members **received** and **noted** the Staffing and Care Report, presented by Mark Richards, Director of Nursing, AHPs & Operations. The report covers the period July to September 2021.

Mark Richards advised that there have been significant challenges on a day to day basis.

There are 272.68 staff in post (not 258.26 in the report; this will be corrected) from the funded establishment of 292 WTE.

Absence is currently running at twice the rate and Covid-19 absence has doubled between July and September. Mark Richards highlighted the absences, number of incidents reported and that adjustments had been put in place to ensure we were delivering safe care.

Mark Richards advised the Committee that he will bring a different report to the next Committee that shows what we are doing to mitigate this and how we are utilising the activity co-ordinators. Every effort is being made to recruit addition staff but it is a very competitive marketplace for registered nurses. 5 conditional offers have gone to staff nurses to commence in December and we have advertised for more with 15 applicants received; it is anticipated that we can fill 50% of the vacancies from these. 11 registered staff are retiring between now and the New Year. We have agreed a temporary variation to the skills mix within the hospital; we have also agreed to bring in 10 nursing assistant posts into the workforce to get capacity at the front line. We are also in the process of engaging with student nurses to bring them in on short fixed term contracts. Gary Jenkins has commissioned a short life working group to look at the possibility of having a nurse bank.

There has been very good support from the psychological therapy service and OT colleagues to changing roles and working differently to ensure safety at the front line.

Stuart Currie stated that this highlights challenges around recruitment in Health and Social Care around the country.

David McConnell advised that he would be attending a national systems pressures meeting on Monday and will discuss issues with Mark Richards and Gary Jenkins outwith the meeting.

Gary Jenkins advised that there are more vacancies than there are applications at present and we need to look at recruitment from a safety perspective as part of business continuity planning; we will continue to do what we can and will keep the Committee and Board up to date on where we are.

Cathy Fallon thanked Mark Richards for this report and looks forward to receiving the next one.

The Committee noted the report.

17 DISCUSSION ITEM

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

Lindsay Thomson asked the Committee if there was any particular area they wished to discuss.

Mark Richards advised that by February we will have the new improved observation policy and least restrictive practice approaches could be an area of discussion.

Monica Merson stated that we are looking at clinical guidance for the new clinical model and would have more detail around what the new wards would look like .

Lindsay Thomson advised that there may also be an update on the Barron review.

Consideration will be given to the first discussion item in 2022 and this will be added to the Agenda.

18 AREAS OF GOOD PRACTICE / AREAS OF CONCERN

The Committee noted one area of good practice:

MAPPA Level 2 Meeting which was convened in response to a situation where there was felt

to be a risk of a patient returning to the community. This meeting was well attended by staff from The State Hospital and community partners and was raised as an example of good practice at the Lanarkshire MAPPA Operational Group.

The Committee also noted one area of concern around ongoing staffing pressures, which are being looked at on a daily basis.

20 WORKPLAN

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

Cathy Fallon asked for the Risk Register to be brought forward on the workplan as it was late coming to the Committee last year.

Lindsay Thomson advised the Committee that the Clinical Governance Group will see an update on the rehabilitation service in 6 months' time and this group will also look at how we are developing outcome work.

21 ANY OTHER BUSINESS

There was no other business raised at this time.

22 DAY, DATE, TIME AND VENUE FOR NEXT MEETING

The next meeting will be held on Thursday 10 February 2022 at 9.45am via MS Teams

The meeting concluded at 12.30pm.

Paper No. 22/08

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	24 February 2022
Agenda Reference:	Item No: 13
Sponsoring Director:	Director of Workforce
Author(s):	HR Advisor
Title of Report:	Attendance Performance Summary
Purpose of Report:	For Noting

1 SITUATION

This report provides information on sickness absence within the State Hospital for the period up to 31 December 2021. It should be noted that this update is the Board level performance summary, a further level of detail is provided within the Staff Governance Committee attendance report (Quarterly) which is also reviewed by the HR and Wellbeing group and Corporate Management Team (both monthly).

2 BACKGROUND

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

3 ASSESSMENT

The current average rolling 12-month sickness figure is 7.15% for the period 1 January 2021 to 31 December 2021. The long/short term split is 5.73% and 1.42% retrospectively. The total hours lost for this period is 82190.84 which equates to 42.14% WTE. This data is produced through SSTS based on direct input at board level, and is dependent on accurate and timely input by line managers.

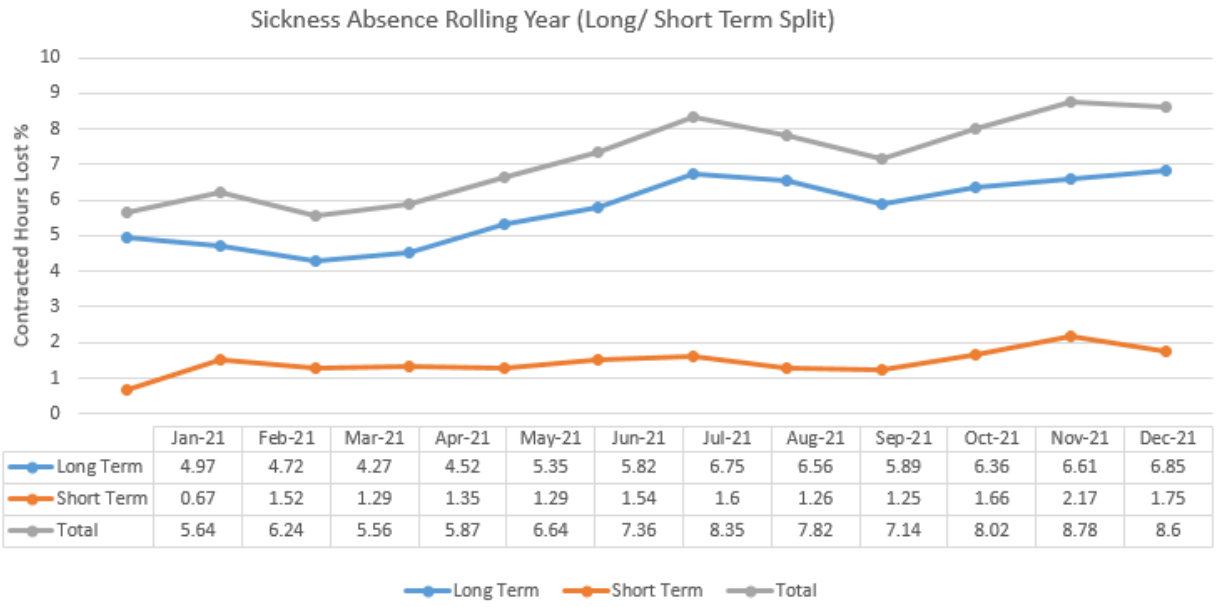
The HR Advisors each have designated departments to support within the Hospital. They work closely with line managers to support the management of long term sickness absence cases, and their regular activities include HR support meetings with line managers to discuss absence cases, running regular SSTS absence reports and liaising with line managers to discuss absence levels.

The HR Advisors for each area check the appropriate paperwork has been received including timely fit notes, Occupational Health referrals have been made and actioned per the Attendance Policy. HR have an internal audit in place to ensure all paperwork has been received in HR.

New Attendance Training has been written and will be implemented to all line managers in 2022. Dates were booked for January 2022 however was postponed due to staffing pressures and will now be conducted on 23 and 24 February 2022.

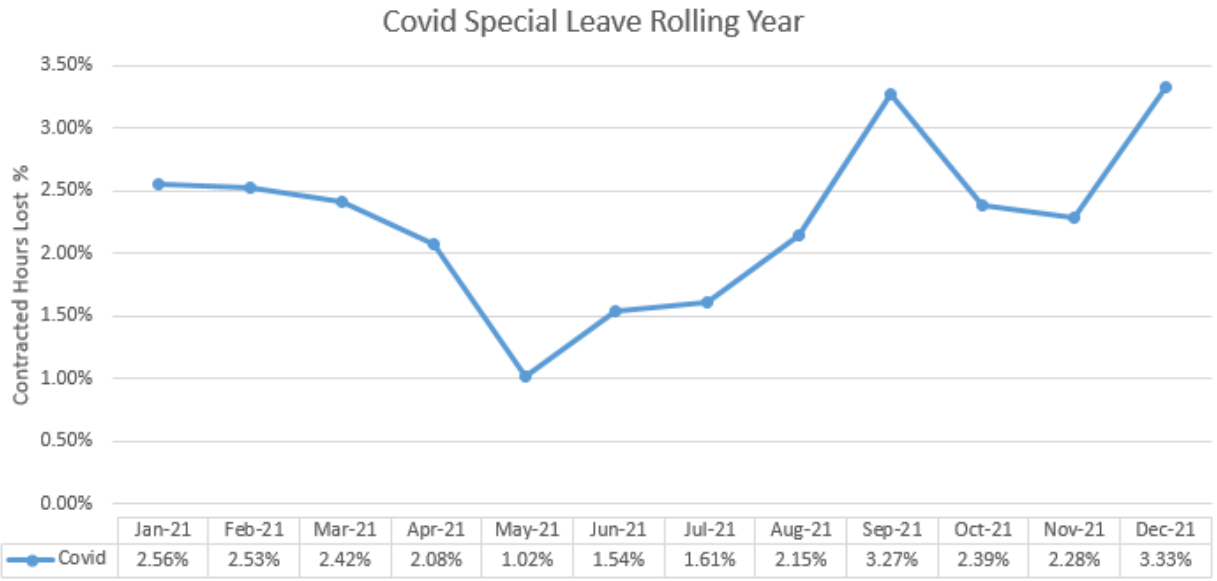
It should be noted that absence data is reporting is based on two sources SSTS (local data) and SWISS (national data). Table 2 is based on SSTS, with Table 4 from SWISS which may bring discrepancies due to the timing of reporting – this is under review to help align reporting data.

Table 1 - Sickness Absence – Rolling Year 1 January 2021 to 31 December 2021 (SSTS)



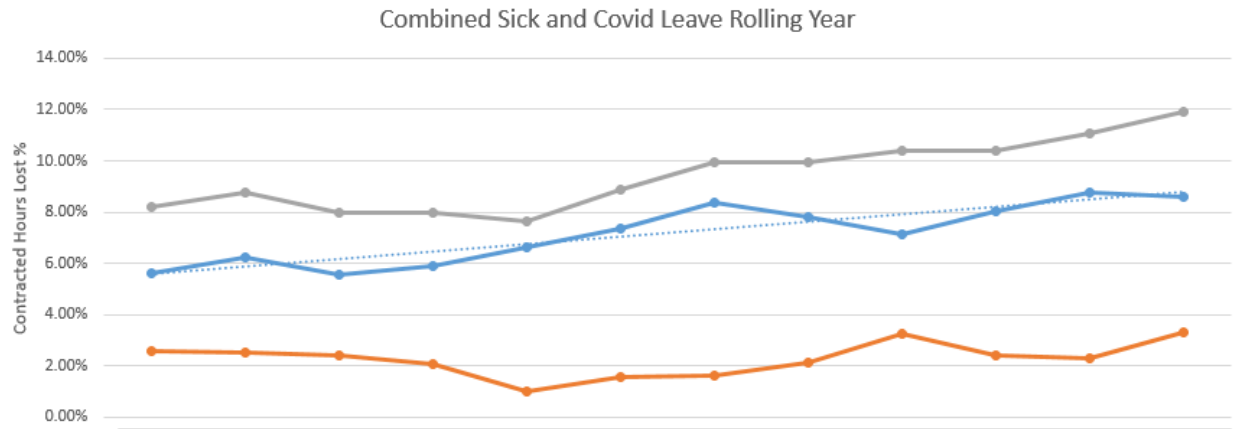
	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Long Term	4.97	4.72	4.27	4.52	5.35	5.82	6.75	6.56	5.89	6.36	6.61	6.85
Short Term	0.67	1.52	1.29	1.35	1.29	1.54	1.6	1.26	1.25	1.66	2.17	1.75
Total	5.64	6.24	5.56	5.87	6.64	7.36	8.35	7.82	7.14	8.02	8.78	8.6

Table 2 – Covid Special Leave - Rolling Year 1 January 2021 to 31 December 2021 (SSTS)



	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Covid	2.56%	2.53%	2.42%	2.08%	1.02%	1.54%	1.61%	2.15%	3.27%	2.39%	2.28%	3.33%

Table 3 - Covid Special Leave/ Sickness Combined - Rolling Year 1 January 2021 to 31 December 2021 (SSTS)



	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Sickness	5.64%	6.24%	5.56%	5.87%	6.64%	7.36%	8.35%	7.82%	7.14%	8.02%	8.78%	8.60%
Covid	2.56%	2.53%	2.42%	2.08%	1.02%	1.54%	1.61%	2.15%	3.27%	2.39%	2.28%	3.33%
Total	8.20%	8.77%	7.98%	7.95%	7.66%	8.90%	9.96%	9.97%	10.41%	10.41%	11.06%	11.93%

Table 4 - National Comparison Data - Rolling Year 1 January 2021 to 31 December 2021 (SWISS)

	Absence Rate			Instances			Absence Reason	
	Total	Long Term [1]	Short Term [2]	Total	Long Term [1]	Short Term [2]	Yes	No [3]
Scotland	**5.49**	**3.74**	**1.75**	**245,282**	**37,269**	**208,013**	**202,488**	**42,794**
NHS Ayrshire & Arran	5.13	3.63	1.49	12,754	2,234	10,520	11,208	1,546
NHS Borders	5.12	3.41	1.71	4,477	644	3,833	3,407	1,070
NHS National Services Scotland [4]	4.15	2.86	1.29	3,949	517	3,432	3,459	490
NHS 24	8.42	5.63	2.78	4,517	647	3,870	4,103	414
NHS Education For Scotland	1.60	1.10	0.50	908	114	794	448	460
Healthcare Improvement Scotland	2.97	1.94	1.03	433	44	389	387	46
NHS Health Scotland [4, 5]	-	-	-	-	-	-	-	-
Public Health Scotland [4, 6]	2.60	1.55	1.06	1,233	105	1,128	958	275
Scottish Ambulance Service	7.53	5.47	2.06	8,974	1,736	7,238	7,853	1,121
The State Hospital	6.20	4.80	1.40	701	202	499	627	74
National Waiting Times Centre	5.45	3.52	1.94	2,966	477	2,489	2,449	517
NHS Fife	5.52	3.85	1.67	11,944	2,102	9,842	10,199	1,745
NHS Greater Glasgow & Clyde	6.08	4.34	1.74	57,718	10,496	47,222	50,569	7,149
NHS Highland	5.05	3.38	1.67	14,138	1,757	12,381	8,970	5,168
NHS Lanarkshire	6.41	4.71	1.70	17,114	3,467	13,647	13,871	3,243
NHS Grampian	4.33	2.52	1.82	25,604	2,479	23,125	18,802	6,802
NHS Orkney	4.64	3.07	1.57	875	110	765	749	126
NHS Lothian	5.04	3.12	1.92	40,393	4,627	35,766	33,333	7,060
NHS Tayside	5.49	3.62	1.87	19,357	2,749	16,608	15,614	3,743
NHS Forth Valley	6.11	4.36	1.75	8,498	1,574	6,924	7,645	853
NHS Western Isles	5.37	3.59	1.78	1,472	202	1,270	1,158	314
NHS Dumfries & Galloway	5.32	3.55	1.78	6,140	883	5,257	5,675	465
NHS Shetland	3.91	2.47	1.44	1,117	103	1,014	1,004	113

4 RECOMMENDATION

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

MONITORING FORM

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

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	24 February 2022
Agenda Reference:	Item No: 9
Sponsoring Director:	Director of Workforce
Author(s):	Director of Workforce
Title of Report:	Whistleblowing Update
Purpose of Report:	For Noting

1 SITUATION

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

2 BACKGROUND

The Whistleblowing Standards that SPSO have developed as a model procedure for handling whistleblowing concerns raised by staff and others delivering NHS services, was formally published on 1 April 2021. For NHS Scotland staff, these form the 'Once for Scotland' Whistleblowing Policy.

3 ASSESSMENT

The State Hospital have fully launched the Whistleblowing Standards and the national policy. This included testing of the Datix template and the launch of Learn-Pro modules as the foundation for staff training complimented by a targeted communications exercise. In terms of numbers of those undertaking the training these are:

Staff Training	-	433 plus 2 in progress
Managers Training	-	28 plus 8 in progress

We intend to send further communications to all staff within TSH, advising that they should undertake this training and bring themselves up to date with the new Standard.

The update from 1 April 2021 to 31 January 2022 is that there are 2 cases raised during this time.

The first case has now been investigated and concluded. The complainant has now been met with and updated on the outcome. At this stage the next steps for this complainant, if they remain, dissatisfied is to raise this direct with the INWO who would ask the Board for information relating to the investigation.

The second case is subject to an ongoing investigation at Stage 2 and remains “live” until this is concluded. The investigation is likely to be ongoing with an Investigation Report available during March 2022. This is however outwith the timescales set within the National Standard due to the complexity of the investigation.

4 RECOMMENDATION

The Board is invited to note the information and confirmation of compliance with the National Policy.

MONITORING FORM

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

Paper No. 22/10

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	24 February 2022
Agenda Reference:	Item No: 15
Sponsoring Director:	Director of Workforce
Author(s):	Organisational Development Manager
Title of Report:	iMatter End of Year Report 2021-2022
Purpose of Report:	For Noting

1 SITUATION

iMatter is the main staff engagement tool for NHS Scotland. It has been delivered annually since 2015 with a short hiatus during the pandemic. On 11 October, The State Hospital received its annual report for 2021. In addition, each team with a response rate of 50% and above received a report, visible only to the team itself and the OD Manager. This report is an account of iMatter over the course of the 2021 cycle, highlighting trends, positive improvements, key areas of challenge and recommendations. It is important to note that the survey results are a snapshot in time and cover a period of great challenge. It is also worthwhile reminding ourselves that in 2020, the iMatter survey was distributed in a modified version as the Everyone Matters Pulse Survey (EMPS). Therefore, comparisons with the previous year are not always possible. Direct comparisons can only be made with reports from 2015-2019. All data printed in red in this report refers to national data.

2 BACKGROUND

This year's iMatter survey was issued on 6th September 2021 with reports available in staff inboxes on 11th October. The survey included demographic questions as well as questions on the types of change staff have experienced.

The key statistics to note locally are:

- 69% of staff responded i.e. 443 staff out of 642 staff.
- 94% of teams received a report as they had response rates of 50% or over. Four teams did not receive a report.
- 68% of teams completed an action plan i.e. 45/66 team.
- The Board's EEI number was 74.

The national Health and Social Care Staff Experience Report 2021 was subsequently issued on 4th February to Chief Exec, Chairs, HRDs EDs and Chief Officers of HSCPs. It was published on Monday 7th February at 10am. The link for this is: https://www.gov.scot/isbn/9781802016222. This information has been shared with staff through the Bulletin.

Every member of staff receives a report directly into their inbox. Reports can be accessed by team leads and they are strongly encouraged to access and discuss information within their teams. This is the basis for a team discussion about action plans and enables teams to make use of the data to improve performance. Directors receive an overview of the Employee Engagement Index (EEI) in their areas as well as the response rates. They also receive their own separate team report.

3 ASSESSMENT

Response rate

This year's response rate to the survey is lower than in previous years, but higher than for the EMPS. This is very possibly due to pressures of staff time and availability due to the pandemic. We will, however, work to ensure this response rate rises in the coming cycle. Four surveys were in paper format, 638 staff were surveyed. 443 responded i.e. 69% response rate. Of these surveys, four were paper copies and only two of these were successfully submitted. Paper copies are often more prone to mistakes and so it is common for a lower response rate where they are used. The State Hospital (TSH) continues to encourage and support all participants to complete the survey online.

The following are the response rates over the past five years, including the EPMS of 2020. Note the higher than average response rate when compared with the national result (printed in red).

2016 TSH / NHS Scotland	2017	2018	2019	EPMS 2020	2021
80% (66%)	78% (63%)	77% (59%)	79% (62%)	48% (43%)	69% (56%)

Interestingly, one of the demographic questions on who responded showed that 75% respondents were female, 19% male and the 6% chose not to answer.

How Directorates Responded

The response rate for 2021 (with comparisons from 2019 and 2020) for each directorate is as follows:

	Chair	Security	CEO	Psychol	HR	DDiT	Psychiat	N&AHP	Fin&Per
2021	86%	66%	92%	73%	94%	67%	90%	66%	62%
2020 (EPMS)	67%	53%	82%	62%	88%	-	72%	39%	69%
2019	67%	82%	87%	92%	88%	-	94%	75%	83%

All directorates have responded at a higher rate than during 2020 (EMPS) when we were at the height of the pandemic. However, a comparison between 2021 and 2019, when iMatter was last delivered, shows a fall in response rates across most directorates.

Reports

94% of all teams (i.e. 62/66 teams) received a report compared with 88% of all teams nationally. The remaining four teams did not receive a report. Three of these teams were small teams with five or fewer staff. In fact, teams that have four staff or fewer are required to achieve 100% response rate required to get the report. For teams of five and over, there must be a response rate of at least 50% to get a report. It is easy to see how smaller teams might not achieve this target. One of the teams did not respond at all, and therefore did not achieve a report.

On a positive note, we had the second highest rate among all of the boards for reports received – four boards achieved a response rate of 95% and one other board achieved 94%. Our board also had the highest response rate for the patient-facing national boards. This is testimony to the encouragement of managers and the communications strategy around iMatter.

Action plans

68% (45/66 teams) of all teams completed their action plan. This compares with 42% of all teams nationally. The State Hospital had the 4th highest number of action plans nationally. The top five boards with a high number of action plans were all national boards. It is not unusual for the national board to score higher, possibly due to smaller population size.

The following table shows the pattern for the completion of action plans at TSH during the 8-week period for completion:

WEEK	NUMBER COMPLETED
3	2 action plans completed
4	3
5	0
6	10
7	24
8	6
TOTAL	**45**

Teams were reminded of deadlines for completion during this period. It can be challenging to get team members together to complete action plans. However, it is important that action plans be completed with full input from the team manager and team members. It is important to emphasise that staff outside of the team should not have access to this data without the permission of the team.

For the purposes of comparison, the following table shows the percentage of action plans and progress plans achieved over a five-year period (excluding 2020).

	iMatter 2016 (65 teams) TSH NHSScotland	**iMatter 2017 (96 teams) TSH NHSScotland**	**iMatter 2018 (92 teams) TSH NHSScotland**	**iMatter 2019 (63 teams) TSH NHSScotland**	**iMatter 2021 (66 teams) TSH NHSScotland**
% Action plans	66% (No data) Adjusted to 98.5% after 12 week deadline	78% (43%) Adjusted to 93% after 12 week deadline	55% (68%) Adjusted to 60% after 12 week deadline	79% (not available%) Adjusted to 82.5% after 12 week deadline.	68% (42%)
% Progress plans	18.5%	15.5%	6.5%	6.3%	4

Progress plans should be updated before the new cycle begins this year i.e. before 25th April when teams start team confirmations.

EEI

The EEI number for 2021 is lower than in previous years. The difference in 3 points between 2019 and 2021 is statistically significant, indicating that this change is very likely to be true and needs our attention. This is not surprising given the events of the last two years. With an increased focus on wellbeing and some additional resource which is being provided to support the wellbeing agenda, it is expected that the situation will improve in the coming year.

2016	2017	2018	2019	2021
74 (74)	76 (75)	77*	77 (76)	74 (75)

*There was no EEI result for 2018, as the threshold response rate of 60% was not reached that year. That threshold was removed in 2021.

Three national support boards increased their EEI scores. All other boards, including all patient-facing national boards, saw a fall in their EEI scores of between two and five points. The State Hospital had a drop of three points.

Looking at the score bands for EEI across all of the teams, and comparing with NHS Scotland, in 2021, most of our teams were in the 'Strive to celebrate' group. However, 18 boards did better in this area. The number of teams in the 'Monitor to further improve' group has increased since 2019. This is a trend that requires serious attention.

	TSH 2017 % teams	TSH 2018 % teams	TSH 2019 % teams	TSH 2021 % teams	NHS Scotland 2021 % teams
Strive to celebrate	72.9%	69.6%	85.7%	77.3% 51 teams	73%
Monitor to further improve	10.4%	6.5%	6.3%	16.7%) 11 teams	14%
Improve to monitor	1%	1.1%	0%	0%	2%
Focus to improve	0%	0%	0%	0	<1%

Performance against the Staff Governance Standard

The questions in the iMatter survey are mapped against the Staff Governance standards to illustrate the level of staff engagement. The following table shows scores against the Staff Governance Standards since 2016 with NHS Scotland scores in red, for comparison.

	iMatter 2016 TSH NHSScotland	**iMatter 2017 TSH NHSScotland**	**iMatter 2018 TSH NHSScotland**	**iMatter 2019 TSH NHSScotland**	**iMatter 2021 TSH NHSScotland**
Performance in Staff Governance Strands					
Well informed	79% (79%)	80% (80%)	81% (80%)	82% (80%)	78% (78%)
Appropriately trained & devel'd	74% (72%)	76% (73%)	77% (74%)	79% (74%)	76% (73%)
Involved in decisions	70% (70%)	72% (71%)	73% (71%)	73% (71%)	70% (70%)
Treated fairly	75% (76%)	77% (77%)	78% (77%)	78% (77%)	76% (77%)
Safe environment	75% (75%)	76% (76%)	77% (77%)	77% (77%)	74% (76%)

There has been a noticeable decline in each of the areas since 2019. 'Well informed' remains the highest scoring area. Communications during the height of the pandemic were frequent and provided clarity about what was happening in the organisation. It continues to be regular and well shared in a variety of formats whether through digital means, use of posters/notice boards or face-to-face.

These scores reflect NHS Scotland scores for the most part, apart from 'Treated fairly' which has remained the same. Apart from the standard 'Appropriately trained and developed', we have performed marginally less well in comparison with previous years where we performed equally well, if not better, than NHS Scotland. Even taking recent events into account, we must acknowledge the importance of the work and resources required to restore morale and wellbeing.

Areas of strength

It is interesting to compare local results against national results. The top areas where staff continue to feel positive are:

The State Hospital	**NHS Scotland**
I am clear about my duties and responsibilities (88: consistently No 1 and generally high across NHS Scotland) My direct line manager is sufficiently approachable (87: consistently No 2) I would recommend my team as a good one to be part of (85: consistently in top 5) (NHS Scotland score of 83) My team works well together (84: consistently in top 5). I am treated with dignity and respect as an individual (82)	My direct line manager is sufficiently approachable (87) I am clear about my duties and responsibilities (86) I feel my direct line manager cares about my health and well-being (84) I have confidence and trust in my direct line manager (84) I am treated with dignity and respect as an individual (83) I would recommend my team as a good one to be a part of (83)

Local results are consistent with previous years and is a good indicator that we have a particular strength around our teams and our team leaders. The national report makes clear that scores on all questions in My Team/My Line Manager tend to be highest among senior managers which is probably not surprising considering the greater degree of control/autonomy senior managers will experience over their area of work.

Staff experience of change

The national report describes changes experienced by staff in a number of areas. Key areas of note, based on those who answered the questions, are:

- 63% of Health and Social Care staff state that they have experienced change in their job role or environment (a slight improvement on the previous year which showed a 74% result for the EMPS.
- The EMPS gave a result of 11% of staff suffering ill health. This has increased to 15% in 2021 and may or may not be related to the pandemic.
- 72% of those who describe themselves as disabled within the definition of the Equality Act 2010 have been impacted by change in circumstances.

These are only some of the data. Further reading of the national report will give a more detailed picture of changes that have been experienced by staff.

Areas of challenge

Areas where the organisation is challenged are listed in the following table. While our scores are lower than the national scores, the TSH response mirrors the national response in terms of the key challenges.

The State Hospital	**NHS Scotland**
I feel that board members who are responsible for my organisation are sufficiently visible (51: consistently in bottom 4)	I feel that board members who are responsible my organisation are sufficiently visible* (55)
I feel sufficiently involved in decisions relating to my organisation (54: however, it is no longer the lowest score as in previous years)	I feel sufficiently involved in decisions relating to my organisation (55)
I am confident performance is managed well within my organisation (55: consistently in bottom 4)	I am confident performance is managed well within my organisation (62)
I have confidence and trust in board members who are responsible for my organisation (56: consistently in bottom 4).	I have confidence and trust in board members responsible for the wider organisation* *(61)

Note:

** The wording of this question has changed from the 2019 statement 'I feel senior managers responsible for the wider organisation are sufficiently visible'.*
***The wording of this question has changed from the 2019 statement 'I have confidence and trust in senior managers who are responsible for my organisation'.*
Some shifts in results from 2019 for these two questions may be attributable to these changes.

Two additional areas are important to note, as scores in the range 51-66 are considered as important to 'monitor to further improve'.

- I feel my organisation cares about my health and wellbeing (Score 65)
- I would be happy for a friend or relative to access services within my organisation (Score 66).

In addition, we are one of four health boards who have scored 0.5 points lower than in 2019 on the overall experience question – 'Overall working within my organisation is a very poor/good experience'.

Team stories

As a result of the COVID-19 pandemic and current challenges, team stories were not requested for 2021. They will, however, be re-introduced in the coming year as a means of demonstrating

the link between action plans and tangible changes and benefits to staff. Managers are advised to work with their teams in developing stories we can share across the system.
Schedule for 2022

The new iMatter cycle for 2022 will be earlier than expected. This is to realign all the boards' timetables following the disruption of the past couple of years. Key dates are:

- 25th April – Distribution starts i.e. team confirmations and adjustments;
- 20th May 2022 - Team managers will be expected to have updated their team information;
- 23rd May 2022 - Survey issued;
- 27th June 2022 - Reports published;
- 22nd August 2022 - Action plans should be completed.

This pattern will be repeated in 2023.

Key challenges for the coming year

- The earlier date for completion of the questionnaire in 2022 may be unwelcome to staff. The support of managers will be required to explain, encourage and motivate their teams to respond;
- Supporting senior managers and leadership team members at all levels to take ownership of and provide visible and committed leadership for iMatter;
- Supporting the wellbeing agenda across the organisation with strong and committed leadership.
- Writing up team stories - team managers will be asked to work with their teams to develop stories that can be shared with the rest of the organisation and other boards. This will be challenging where there are competing demands on time;

4 Recommendations

The Staff Governance Committee reviewed this report in detail at its meeting on 17 February 2022. The Board is now invited to note the contents of this report.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	To the Wellbeing Agenda and iMatter.
Workforce Implications	Considered in this report
Financial Implications	None identified
Route To Board Which groups were involved in contributing to the paper and recommendations.	Staff Governance Committee
Risk Assessment (Outline any significant risks and associated mitigation)	Fully outlined and considered in the report
Assessment of Impact on Stakeholder Experience	Fully outlined and considered in the report. It is well evidenced that good workforce morale is directly linked to a more positive patient and staff experience
Equality Impact Assessment	Screened and no implications identified for reporting.
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	There are no identified impacts.
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One X There are no privacy implications. □ There are privacy implications, but full DPIA not needed □ There are privacy implications , full DPIA included.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Minutes of the meeting of the Staff Governance Committee held on Thursday 18 November 2021 at 9.45am via MS Teams, The State Hospital, Carstairs. SGC(M)21/04

Chair:

Non-Executive Director	Pam Radage

Present:

Non-Executive Director	Stuart Currie
Non-Executive Director	Cathy Fallon
Employee Director	Allan Connor

In attendance:

Organisational Development Manager	Jean Byrne
Director of Workforce	Linda Davidson
Training and Professional Development Manager	Sandra Dunlop
Chief Executive	Gary Jenkins
Lead Nurse	Jackie McQueen
Head of Corporate Planning & Business Support	Monica Merson
UNISON Staff-Side Representative	Michelle McKinlay
Board Chair	Brian Moore
POA Staff-Side Representative	Richard Nelson
Learning and Wellbeing Advisor	Gayle Scott
Board Secretary	Margaret Smith
Professional Nurse Advisor	Carolin Walker
Personal Assistant	Julie Warren ***(Minutes)***

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

Pam Radage welcomed everyone to the meeting. Mr Allan Connor, Employee Director was welcomed to his first meeting as Employee Director.

2 CONFLICTS OF INTEREST

There were no conflicts of interest raised.

3 MINUTES OF THE PREVIOUS MEETING HELD ON 29 AUGUST 2021

The Committee approved the Minutes of the previous meeting held on 29 August 2021 as an accurate record.

4 ACTION POINTS AND MATTERS ARISING FROM THE PREVIOUS MEETING

Safe Staffing Report

Ms Smith noted that the committee had previously agreed the appropriate governance routes in this area through this Committee as well as the Clinical Governance Committee, and that the action should be considered closed.

Occupational Health – Service Legal Agreement
The Service Level Agreement (SLA) expires March 2022. Members were content that a Short Life Working Group was established to draft Terms of Reference and would meet regularly until January 2022 on proposals to take forward prior to SLA expiring. It was agreed that the action should remain open and noted to be in progress.

AOCB
Information shared on 19 August 2021 by Rhona Preston, Personal Assistant. Action was closed.

STANDING ITEMS

5 ATTENDANCE MANAGEMENT REPORT

Members of the Committee received and noted the report up to 30 September 2021, as presented by Linda Davidson, Director of Workforce.

The sickness absence figure from 1 September 2021 to 30 September 2021 was 7.16% with the long/short term split being 6.12% and 1.04% respectively. The total hours lost for this period was 6,806 which equates to 41.81 WTE.

The monthly absence figure decreased by 0.66% from the August 2021 figure of 7.82%. The August 2021 long/short term split was 6.56% and 1.26% respectively.

The current average rolling 12-month sickness figure was 6.62% for the period 1 October 2020 to 30 September 2021. The long/short term split was 5.40% and 1.22% retrospectively. The total hours lost for this period was 75,860 which equates to 39.90% WTE.

The average rolling 12-month sickness absence figure represents a decrease of 0.72% when compared to the same period last year, with the average rolling absence figure from 1 October 2019 to 30 September 2020 reported at 7.34%.

There was discussion around the levels of absence in particular the long-term absence which was considered to be concerning due to the upward trend. Richard Nelson queried whether there was additional focus required in terms of utilising the Occupational Health Service (OHS) to its full potential as he was concerned about the possibility of staff being unable to obtain appointments prior to returning to work. Linda Davidson confirmed that she would liaise with the OHS in this regard to ensure best use of the service to support staff. Mr Connor added that he had been aware of a good response rate by the OHS in this regard.

Action: Linda Davidson

Mr Currie sought reassurance that staff on long term sickness absence were being afforded the opportunity to return to work within a different role. Ms Davidson confirmed this remained current practice and was routinely addressed on a case by case basis. Directors were asked to take leadership on reviews within their own remits, especially on long term absence to identify any emerging patterns of absence as well as to ensure that staff were being provided with the full range of support available to help them return to work.

Mr Currie also asked whether increased funding for wellbeing strategies could provide further support for staff. Mr Jenkins confirmed that there was recognition of the need for a dynamic strategy around changing circumstances in this regard, and a focus on using all resources available. He added that the Wellbeing strategy currently under development had been reviewed by the Corporate Management Team (CMT) confirming that this was a key area for the organisation.

Ms Fallon asked whether study leave could be impacted, affecting staff development and Ms Davidson agreed to look into this aspect further and provide an update to the committee, placing this in the wider context of recruitment and retention of staff.

Action: Linda Davidson

Members noted the report and welcomed the assurances given.

6 HUMAN RESOURCES PERFORMANCE – EMPLOYEE RELATIONS ACTIVITY

Members of the Committee received and noted the Employee Relations Activity Report to 30 September 2021 as presented by the Director of Workforce. Ms Davidson summarised the report and rolling activity from April to end of October 2021.

The committee noted the timescales for progressing these cases, underlining the importance of managing cases without delay. Ms Davidson was asked to take forward an action to identify whether it would be possible to benchmark data with other NHS Boards, to place this in a national context.

Action: Linda Davidson

The committee noted the report.

7 PERSONAL DEVELOPMENT PLAN REPORT

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

As at 31 October 2021, the total number of current (i.e. live) reviews was 528 (87%) - a decrease of 4.2% from the previous update in July 2021.

As at 31 October 2021, a total of 62 staff (10.2%) had an out-of-date PDPR (i.e. the annual review meeting is overdue) – an increase of 3.1% from 31 July 2021.

A further 17 staff (2.8%) had not had a PDPR meeting – an increase of 1.1% from July 2021. Staff in this group are predominantly new staff with an initial set-up review meeting overdue.

There was discussion around the impact of completing PDRs when there were sickness and capacity issues with staff.

In response to a query around completion of Personal Development Plans, it was noted that these were being progressed with updates to the TURAS (electronic system) to be completed to evidence this. Members were content to note the report.

8 WHISTLEBLOWING QUARTERLY REPORT

Members received and noted the Whistleblowing update as presented by the Director of Workforce.

Ms Davidson advised that The State Hospital had fully launched the Whistleblowing Standards and the national policy during 2021 in accordance with the national guidance in this area. This included testing of the Datix (the electronic platform used to record cases) and the launch of Learn-Pro

modules as the foundation for staff training complimented by a targeted communications exercise. In terms of numbers of those undertaking the training these were confirmed as;

Staff Training - 392 plus 6 in progress
Managers Training - 23 plus 10 in progress.

It was recognised that one case was raised during the period 1 April 2021 to 31 October 2021. This case was subject to investigation at stage 2 within the standards. However, the case investigation remained open to allow feedback to be provided as set out in the process, and this was being progressed as quickly as possible, subject to individual circumstances.

Mr Brian Moore advised of a letter received from the Cabinet Secretary for Health and Wellbeing requesting a progress report in terms of how the Board were approaching Whistleblowing. A Whistleblowing report would be submitted to the Board meeting in December 2021. This would cover the period until July 2021 only, at which point the role of Non- Executive Whistleblowing Champion became vacant. It was understood that the Scottish Public Appointments Team will oversee the recruitment process for this vacancy.

Members noted the update and were content with compliance with the National Policy.

ITEMS FOR DISCUSSION

9 STATUTORY AND MANDATORY TRAINING COMPLIANCE - APRIL TO SEPTEMBER 2021

The Committee received and noted the Bi-annual Statutory and Mandatory Training Compliance update as at 30 September 2021. Ms Dunlop, Training & Professional Development Manager provided a brief overview of this. For awareness, an error was declared within part 3 'Assessment' of the report on page 2 whereby the date should be recorded as 30 September 2021 and not 31 March 2021.

The organisational compliance levels for statutory and mandatory training at 30 September 2021 were;

Statutory Training - 90.9% compliance, a decrease of 1.7% from March 2021.

Mandatory Training - 82.3% compliance, a decrease of 2.8% from March 2021.

The above compliance figures were calculated as an average, based on compliance levels for all statutory and mandatory courses within the Corporate Training Plan and were recognized to have reduced since the previous update in March 2021.

The Committee recognised that the decrease in compliance was due primarily to the continued impact of the Coronavirus pandemic (and associated restrictions in relation to face-to-face training delivery), combined with levels of sickness absence, and the overall capacity to release staff to undertake training.

In response to a COVID-19 outbreak on site, all non-critical face-to-face training delivery was temporarily suspended in July 2021. This resulted in the cancellation of 14 scheduled courses within that month. A further seven scheduled courses were cancelled during August and September due to staffing deficits or unavailability of the course facilitators due to sickness absence.

Ms Fallon queried whether staff sickness absence related to musculoskeletal illness, had any correlation to compliance with Manual Handling Training. Confirmation was received that evidence

did not prove this correlation, also in terms of further reassurance, the members were advised that the Manual Handling Advisor reviews all Datix Incident reports related to a manual handling injury.

The Committee noted that although the downward trend in compliance, Members were content to note the report as being postive overall.

10 iMATTER REPORT

The Committee received and noted the iMatter update dated November 2021 which Ms Byrne, Organisational Development Manager, provided a brief overview of. Following this year's iMatter questionnaire issued on 9th August 2021, 69% of staff responded. 94% of teams received a report given they had a response rate of 50% or over. The Board's Employee Engagement Index number was 74, which was a drop in three points. The Committee recognised the decrease of overall scores compared to the previous five-year period.

At the time of reporting, five out of 66 Action Plans due by 6 December 2021 had been submitted. Outstanding action plans were being flagged with Managers to urge completion. Ms Byrne advised that a national report was expected to be available by the end of the calendar year.

In terms of visibility of Board Members, Ms Smith advised that this was a wider NHS issue which was consistent across other NHS Boards in Scotland. Work was in progress to afford Non-Executive Directors the opportunity to come on site during 2022 to attend Patient Partnership Groups and to link in with Leadership Walkrounds.

The Committee were content to note this report.

11i HEALTHY WORKING LIVES UPDATE

Members received and noted the Healthy Working Lives update dated November 2021 which Ms Byrne, Organisational Development Manager, provided a very detailed overview of.

The Healthy Working Lives Team were praised by the Committee on the extensive and proactive work achieved and planned interventions over the following months.

In terms of a sense check on uptake of activities and intervention Mr Moore queried whether information on attendance and uptake was available to capture this data. Ms Byrne advised that although face to face training was recorded, this was more challenging in respect to daily footfall within the Wellbeing Centre. Mr Currie followed this up by asking how it would be possible to take the positives from this approach, which were underpinned through a diverse range of policies, and share good practice and learning across the whole organisation. Further, how would it be possible to monitor the effectiveness of this approach. Ms Fallon agreed with this and also thought that this should be linked to the previous discussion on levels of sickness absence and the actions being taken in that regard.

Ms Byrne acknowledged that there was further work to be progressed in terms of monitoring and evaluating effectiveness and would take this as an action to consider and provide advice on. Similarly, she would link consideration of this to levels of staff absence, for a coherent and wide-ranging approach. The Committee recognised there was no medical representative within the Healthy Working Lives group. Jean Byrne agree to take this query forward and to establish whether this was an omission.

Action(s): Ms Byrne

The Committee were content to note this update report.

11ii DRAFT WELLBEING STRATEGY

Members received and noted The State Hospital Wellbeing draft strategy 2021 – 2024. Ms Walker, Professional Nurse Advisor, offered members an update by way of a power point presentation.

The draft proposal outlined the current function of the Wellbeing Centre managed by HR Directorate and supported activity, the aims and framework for wellbeing in particular areas and how staff engagement would underpin all work related to staff wellbeing. Implementation was noted to be over a three-year period. Monitoring & evaluation as well as the reporting structure was included in the report.

Mr Currie underlined the importance of this workstream, and was pleased to note the consideration being given to succession planning for the organisation's Wellbeing Champion (given Ms walker's planned retirement in 2022). Ms Fallon agreed with this, and added that it may be helpful to contextualise the approach being taken through Maslow, to ensure wider understanding of the strategy. She also asked for further consideration of the role of the TSH Board in this strategy, so that a holistic approach could be taken.

Action(s) – Ms Walker

In terms of staff engagement, Mr Moore queried which approach would be taken to capture staff views. Ms Walker advised that wellbeing staff intend on visiting departments across the site to promote and speak with staff individually.

The Committee thanked the Wellbeing Team for the very useful update, and noted the position. Of particular recognisance was the report being action orientated and the Committee look forward to future developments within this area.

12 STAFF GOVERNANCE COMMITTEE DRAFT WORKPLAN 2022

The Committee received and noted the draft workplan for 2022. Members approved content of same, noting only that the routing and timing of reporting on the Wellbeing Strategy should be verified by Ms Davidson.

Action – Ms Davidson

ITEMS FOR INFORMATION

13 NHS SCOTLAND STAFF GOVERNANCE STANDARD MONITORING FRAMEWORK 2020 - 2021

Members received and noted the NHS Scotland Staff Governance Standard Monitoring Framework 2020 – 2021.

14 APPROVED MINUTES FROM PARTNERSHIP FORUM FROM 28 SEPTEMBER 2021

Members received and noted the approved minute.

15 APPROVED MINUTES FROM HR AND WELLBEING GROUP FROM 14 SEPTEMBER 2021

Members received and noted the approved minute.

ANY OTHER COMPETENT BUSINESS

16 ANY OTHER BUSINESS

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

17 DATE AND TIME OF NEXT MEETING

The next meeting will take place on **Thursday 17 February 2022 at 9.45am via MS Teams**.

Meeting concluded at 1130 hours.

Board Paper 22/11

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	24 February 2022
Agenda Reference:	Item No: 17
Sponsoring Director:	Chief Executive Officer
Author(s):	Board Secretary
Title of Report:	Corporate Objectives 2022 - 23
Purpose of Report:	For Decision

1 SITUATION

The Board undertakes a review of its corporate objectives annually. This document sets out the draft Corporate Objectives for The State Hospitals Board for Scotland for the period 1 April 2022 until 31 March 2023.

2 BACKGROUND

The intention of the corporate objectives is to provide a summary of the strategic priorities for the organisation, and to support our key aims and mission.

The Corporate Objectives should align with the operational business model for The State Hospital and support remobilisation priorities in response to the continuing impacts of the Covid-19 pandemic.

3 ASSESSMENT

The draft Corporate Objectives are attached (**Appendix A)** and group the key aims around the themes of Better Care, Better Health, Better Values and Better Workplace.

- Improve the quality of care for patients by targeting investment and focus at improving services with the high security environment and for providing the most effective support for all. **(Better Care)**

- Improve health and wellbeing by promoting and supporting healthier lives and choices, addressing inequality and adopting an approach based on recovery, care and treatment. **(Better Health)**

- Increase the value from, and financial sustainability of, care by making the most effective use of available resources through efficient and effective service delivery **(Best Value)**

- Improve the engagement of staff and opportunity for development through effective values based leadership resulting in a culture of quality and accountability **(Better Workplace)**

The performance management framework underpinning delivery of these objectives is through:

- Individual performance within the senior leadership team, measured against objectives.
- Directorate/ team performance against objectives.
- Board review of performance and accountability of Executive leadership
- Annual Review process

It is recognised that delivery of the Corporate Objectives may continue to be impacted by the Covid-19 pandemic, and that there does remain a risk factor of unknown longer term impacts.

Additionally, the national framework for delivery of forensic mental health services in NHS Scotland, is under active review with reporting and potential implementation of a changed national model expected during 2022/3. Therefore, it is recognised that The State Hospital's Corporate Objectives may be subject to review by the Board throughout this period.

4 RECOMMENDATION

The Board is asked to review the Draft Corporate Objectives and recommend any changes required before providing approval.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	To present the draft corporate objectives 2022 to the NHS Board for their consideration and approval.
Workforce Implications	The Corporate Objectives detail our key strategic aims for a better workplace; providing a framework through which impacts on the workforce can be considered through any strategic planning for the year.
Financial Implications	To underpin the key aim of better value for the organisation, stating the intent that this will underpin strategic planning and financial management.
Route To Board Which groups were involved in contributing to the paper and recommendations.	Corporate Management Team/ requested as part of the Board's workplan.
Risk Assessment (Outline any significant risks and associated mitigation)	No specific risk assessment made, this supports the organisational delivery of key objectives.
Assessment of Impact on Stakeholder Experience	Key stakeholders and the need to align the corporate objectives to these is outlined in the paper.
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 issues identified
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One X There are no privacy implications. □ There are privacy implications, but full DPIA not needed □ There are privacy implications , full DPIA included.

Appendix A **TSH Draft Corporate Objectives 2022/23**

Better Care	▪ Safe delivery of care within this context with sustained organisational resilience, and the ability to identify and respond to Risk ▪ Learn locally and nationally from adverse events to make service improvements that enhance the safety of our care system ▪ Ensure organisational resilience and ability to respond to any increase in risk to care delivery due to the continuing Covid-19 pandemic ▪ Deliver the Operational Plan (Year 1) within the overall three-year planning framework for 2022/25 ▪ Implement the Clinical Model, enabling TSH to provide a progressive care approach for patient treatment and recovery ▪ Ensure the principles of the rehabilitative care maximizing opportunity for patient activity and ensure delivery across all service areas ▪ Deliver care and treatment within the framework of least restrictive practice ▪ Monitor the use and recording of seclusion practice in accordance with the definitions published by the Mental Welfare Commission ▪ Collaborate with the Forensic Network in the delivery of quality care guidance and standards applicable to the Forensic Mental Health Environment ▪ Be accessible to patients, their family and visitors whilst accessing care and treatment ▪ Work with stakeholders and Scottish Government representatives to enhance the reputation and develop the healthcare profile of The State Hospital ▪ Take forward national collaboration with the Health in Custody Network ▪ Deliver a programme of Infection Control related activity in line with all national policy objective ▪ Respond to development of national programme and developing framework for change in the delivery of forensic mental health services across NHS Scotland

Better Health	▪ Tackle and address the challenge of obesity, through delivery of the Supporting Healthy Choices programme ▪ Improve the physical health opportunities for patients ▪ Ensure the delivery of tailored mental health and treatment plans individualised to the specific needs of each patient ▪ Address the overall social wellbeing issues for patients undergoing treatment ▪ Utilise connections with other health care systems to ensure patients receive a full range of healthcare support ▪ Align with the aims and ambitions of medium secure provision and other treatment pathways to provide cohesive care and treatment for patients transferring to other services ▪ Ensure the organisation is aligned to the values and objectives of the wider mental health strategy and framework for NHS Scotland
Better Value	▪ Meet the key finance targets set for the organisation and in line with Standard Financial Instructions ▪ Develop a sustainable finance model which supports the sustainability of the organisation ▪ Enhance and strengthen digital innovation and inclusion programme ▪ Deliver the security upgrade for the safety of staff, patients and the general public ▪ Work collaboratively across public sector bodies to ensure that best value is achieved in service planning, design and delivery as well as procurement for services ▪ Strengthen corporate governance to ensure transparency and clear direction, within and external to, the organisation ▪ Support quality improvement approaches, embedding a cohesive approach ▪ Ensure delivery of the performance management framework, linked to the principles of 'Active Governance'

	▪ Ensure delivery of a cohesive approach to information governance standards
Better Workforce	▪ Agree 3-Year Workforce Plan and deliver Year 1 Plan within the context of the planning framework and guidance from Scottish Government. ▪ Agree an assurance model to support the implementation of the Health and Care (Staffing) (Scotland) Bill (2019) across TSH, following national rollout. ▪ Deliver a program of supplementary staffing, ensuring this is implemented in partnership. ▪ Promote and deliver a framework of culture change within the framework of a Staff Wellbeing Strategy ▪ Continue with the Healthy Working Lives programme and activities for the benefit of staff, aligning this with the Staff Wellbeing Strategy. ▪ Building on i-matter and staff governance principles to deliver an inclusive staff engagement programme in partnership to support the wellbeing of all employees ▪ Sustain a safe working environment for staff with a focus on risk management across all aspects of the organisation ▪ Implement the 'Once for Scotland' suite of Human Resources policy, aligning with the national rollout ▪ Ensure accessibility to support to internal and external services for staff who require them, including a cohesive Occupational Health Service. ▪ Review and action absence related issues and staff wellbeing to provide staff and line managers with the support required to help staff return to work where possible. ▪ Continue to support training and development for all staff across the organisation ▪ Ensure partnership working is embedded across the organisation ▪ Support the Independent National Whistleblowing Policy, and support this workstream locally including promoting awareness for staff.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	24 February 2022
Agenda Reference:	Item No: 12
Sponsoring Director:	Finance and eHealth Director
Author(s):	Deputy Director of Finance
Title of Report:	Financial Position as at 31 January 2022
Purpose of Report:	For Noting

1 SITUATION

The Board is asked to consider the Revenue and Capital Resources spending plans, and monitor financial outturn. This report provides information on the financial performance, which is also issued quarterly to Scottish Government (SG) along with the statutory financial reporting template. It is also reported internally to fit in with the new Management Structure (April 2021).

2 BACKGROUND

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

At SG's request, TSH formally sought six months' funding for Covid-related costs, based on half of last year's funding provision. Following an initial July payment, a second sum was received in October's allocation for the second six months of the year, on the same basis as the first allocation and for further review closer to year-end (refer to further note in 3.2).

There are potential delays in the Perimeter Project which are being monitored by the Project Board and for which any delay costs will be quantified for consideration (likely into 2022/23) where there has been a Covid related impact.

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

3 ASSESSMENT

3.1 Revenue Resource Limit Outturn

The annual budget of £40.701m is primarily the forecast Scottish Government Revenue Resource Limit core and non-core allocations, and anticipated additional allocations.

The Board is reporting an under spend of £0.223m to 31 January 2022. The movement in month is taking cognisance of the risk of any provisions included within recoverable balances.

PAIAW funding is now being released monthly – being a significant element for the Board because of our high levels of overtime and high Nursing vacancies.

3.2 Key financial pressures / potential benefits.

Revenue (RRL): -

Office 365

An accrual was set aside March 2021 to help address the licence cost pressure, which is being monitored with the Head of eHealth, and for which the various licence options are currently under evaluation with regard to cost scoping, in line with national guidance and local priorities.

Covid-19

We have received two allocations to date in June (Q1 Covid Funding 21/22 – NR) £338k. and in October ('Further general Covid funding 21/22 – N/R) £369k. A review of spend through the remaining months will determine any adjustments to these allocations towards the year-end and if there are further pressures materialising or if any release is required to be handed back to 'SG' should the funding be in excess.

Clinical Model review update

There is risk noted that the updated Clinical Model review is expected to differ in structure from that which was originally considered and evaluated pre-Covid. Any additional cost pressures arising will be established and reviewed as part of the overall process.

Patient Visiting

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

eRostering

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

PAIAW

Some pressure potentially remains re prior years still outstanding – claimants being in the hand of CLO (some of whom have recently been paid.)

Travel

As previously acknowledged, benefits have arisen due to most meetings and courses now being virtual through the Covid crisis, with future budgets being set accordingly.

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 10	Budget WTE	Actual WTE
Nursing And Ahp's	22,626	18,907	19,142	(234)	401.63	417.06
Security And Facilities	6,579	5,502	5,415	87	120.64	115.50
Medical	2,967	2,472	2,355	117	21.70	21.52
Chief Exec	1,948	1,629	1,523	105	22.07	19.47
Human Resources Directorate	970	814	793	21	14.05	13.86
Finance	2,789	2,333	2,299	34	29.02	30.61
Cap Charges	2,857	2,381	2,145	236	0.00	
Misc Income	(600)	(526)	(474)	(53)	0.00	0.00
Central Reserves	565	(438)	(348)	(90)	(1.00)	0.00
	40,701	**33,074**	**32,851**	**223**	**608.11**	**618.02**

Nursing, and Security – see further detail below.

Medical – Underspends are noted in research (arising from delays in certain projects) and Medical Non Pay (travel and course fees – effect of pandemic).

CE –There has been structural realignment to some budgets (Corporate Services) for which adjustments are being finalised.

HR – An underspend is noted in the Learning Centre's corporate training.

Finance – Pay savings are noted in the Finance department and non-pay underspends throughout the Directorate.

Capital Charges –The budget is currently carried forward from previous year, awaiting SG confirmation of the required change to the allocation for the forecasted 2021/22 position (core to non-core adjustment). This transfer / benefit may be considered for evolving pressures.

Miscellaneous Income (MI) – The budget now recognises income billed for exceptional circumstance patients, also a write-off of certain older items previously provided. In month we have included the risk of non-payment of any items considered at risk.

Central reserves – Significant reserves are for Covid, Apprenticeship Levy and AME, and any additional RRL not yet released (due to delay in projects), being offset with unidentified savings.

Nursing And Ahp's	Annual Budget £'k	Year to Date Budget £'k	Year to date Actuals £'k	YTD Variance (budget less actuals) for period 10	Budget WTE	Actual WTE
Advocacy	148	123	125	(1)	0.00	0.00
AHPs & Dietetics & SLAs	716	597	479	118	13.33	14.99
Hub & Cluster Admin & Clinical Operations	864	721	642	78	24.97	22.37
NPD & Infection Control & Clin Gov	471	397	363	34	5.80	5.50
Psychology	1,388	1,157	1,199	(42)	19.50	18.82
PA's (pending NOC's)	42	42	242	(200)	0.00	5.68
PCI & Pastoral	228	190	183	7	3.40	3.67
Skye Centre	1,813	1,514	1,397	117	37.33	35.01
Ward Nursing	16,955	14,166	14,511	(345)	297.30	311.02
	22,626	**18,907**	**19,142**	**(234)**	**401.63**	**417.06**

Highlights from Nursing & AHPs: -

AHPs etc. & Skye Centre – reflects vacancies in year.

Hub & Cluster Admin plus PAs - There has been structural realignment to some budgets, for which adjustments are awaiting finalisation.

NPD etc. – reflects vacancies in NPD.

Psychology – reflects savings not realised.

PCI – Visitors travel underspend is noted, in line with expectations.

Ward nursing – Overtime equates to actual WTEs worked. Covid funding now being released monthly, similarly for PAIAW, to match spend. There are also savings not yet realised.

Security And Facilities	Annual Budget £'k	Year to Date Budget £'k	Year to date Actuals £'k	YTD Variance (budget less actuals) for period 10	Budget WTE	Actual WTE
Risk & Resilience	127	106	92	13	2.00	2.00
Facilities	4,649	3,886	3,769	117	78.87	74.15
Security	1,803	1,510	1,552	(42)	39.77	39.35
Perimeter Security	0	0	2	(2)	0.00	0.00
	6,579	**5,502**	**5,415**	**87**	**120.64**	**115.50**

Highlights from Security and Facilities: -

Risk & Resilience – Noted benefit of new start not in post from the start of the year.

Facilities – Housekeeping vacancies and kitchen vacancies noted, also holiday pay not fully utilised (necessitating a revision required to the future budget). Utilities currently record an overspend – being an unpredictable forecast dependant on seasonal demands.

Security – Some of the overtime and on-call pressures are met from Covid funding, monthly. Other overtime has arisen from high sickness levels.
Perimeter – This minor balance will clear to the Capital budget.

4 ASSESSMENT – SAVINGS

The following table summarises the savings set by Directorate.

Cumulative Savings	Savings - Annual Target	Achieved to date / post base adj'ts	(Still to be achieved) / over achieved
Directorate	**£'k**	**£'k**	**£'k**
Chief Executive	(143)	108	(35)
Finance	(26)	34	8
Nursing & AHP's	(392)	377	(15)
Human Resources	(15)	3	(12)
Medical	(20)	35	15
Security & Facilities	(215)	283	68
Unidentified (phased ytd) - so all 'achieved'	(438)	(106)	(544)
Total	**(1,249)**	**734**	**(516)**

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

Although unidentified savings are significant the budget is phased evenly over the year against monthly underspends but just not specifically matched to ledger codes.

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

5 CAPITAL RESOURCE LIMIT

The recurring capital allocation anticipated from Scottish Government for the year is £0.269m. £0.500m now received Dec 21 for Key Safes & MSR's.

£0.052 has been released to Capital from Revenue for an earlier VAT correction.

With regard to the Perimeter Security Project allocation, £2.879m was received in December 2021 being for year 2 of 2. While there are elements of unforeseen delays in the project – likely now to June 2022 – this will require unspent monies to be carried forward from year-end to close in the next financial year.

CAPITAL CRL 2021/2022 AS AT January 2022	ANNUAL PLAN	YTD PLAN	YTD SPEND	under/ (over)
PERIMETER SECURITY	£'k	£'k	£'k	£'k
STANLEY SECURITY SOLUTIONS LTD		1,646	1,646	0
DOIG & SMITH		1	1	0
THOMSON GRAY LTD		149	149	0
TSH STAFFING APR - JAN'22		171	171	0
DJ GOODE		18	18	0
SENSTAR CORP		20	20	0
VAT RECLAIM		-55	-55	0
PERIMETER SECURITY TOTAL (Yr 1 of 2)	**2,879**	**1,950**	**1,950**	**0**
CAPITAL				
IM&T		27	27	0
OTHER		79	79	0
CAPITAL	**269**	**106**	**106**	**0**
SECLUSION ROOMS & KEY SAFES		12	12	0
CAPITAL	**500**	**12**	**12**	**0**
Total CRL	**3,648**	**2,068**	**2,068**	**0**

6 RECOMMENDATION

Revenue
Year to date position is £0.223m underspend, with breakeven anticipated for the year-end, however further consideration of hand back or carry forward of Covid monies will be finalised in Q4 (monies not yet utilised are sitting in period 12 – Mar '22).

Capital
Spend is not scheduled in even twelfths through the year, so we currently reflect funding received as matched to spend to date, with breakeven anticipated for the year-end for CRL, but as noted above delays in the Perimeter Security project means unspent monies due to delays will require to be carried forward to 2022/23 – with an anticipated end date of mid-June.

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

MONITORING FORM

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

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	24 February 2022
Agenda Reference:	Item No: 19
Sponsoring Director:	Director of Security, Resilience and Estates
Author(s):	Programme Director / Head of Estates and Facilities
Title of Report:	Perimeter Security and Enhanced Internal Security Systems Project
Purpose of Report:	For Noting

1. SITUATION

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

2. BACKGROUND

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

The Project Oversight Board meets monthly. The POB last met on 17th February 2022 and is scheduled to meet again on 17th March 2022.

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

3. ASSESSMENT

a) General Project Update:

Quality targets are being met, project costs are projected to overspend by a small amount (See Finance – Project Cost at point 3f) and project timescales have been reviewed and adjusted (See "Project Timescale" at point 3e below).

A strategic overview of progress during the period of February 2020 to date is below:

Activity	Metric
OVERALL	
Package Workface % Complete	70%
Duration % Complete (Percentage of Overall Project Duration)	83%
Procurement	
No of approved Procurement Packages complete	24
No of Procurement Packages in progress	0
No of Procurement Packages to be commenced	0
Package Workface % Complete	100%
Duration % Complete (Percentage of Overall Procurement Duration)	100%
Detailed Design Packages	
No of approved Detailed Packages complete	26
No of Detailed Packages in progress	2
No of Detailed Packages to be commenced	0
Package Workface % Complete	96%
Duration % Complete (Percentage of Overall Design Package Duration)	96%
Cause & Effect Documents	
No of approved C&E complete	7
No of C&E in progress	1
No of C&E to be commenced	1
Package Workface % Complete	83%
Duration % Complete (Percentage of Overall C&E Documentation Duration)	83%

Construction Health & Safety Documentation	
No of approved RAMS complete	27
No of RAMS in progress	1
No of RAMS to be commenced	14
Package Workface % Complete	65%
Duration % Complete (Percentage of Overall RAMS Documentation Duration)	89%
Construction Phase - Site Works	
No of Workfaces complete	14
No of Workfaces in progress	7
No of Workfaces to be commenced	18
Package Workface % Complete	45%
Duration % Complete (Percentage of Overall Construction Programme Duration)	82%
Testing & Commissioning	
No of activities complete	0
No of activities in progress	0
No of activities to be commenced	27
Package Workface % Complete	0.00%
Duration % Complete (Percentage of Overall T&C Duration)	0.00%

e) Project Timescales & Quality Issues:

As previously reported, the project planned completion date moved from mid October 2021 due to the impact of COVID, delays on approval of Design Packages and Risk and Method Statements. Further programme extensions followed and another revised programme has been accepted with caveats. This projects completion in mid-June 2022, exceeding the contract completion date by approximately eight weeks. The programme includes issues that have the potential to create further slippage.

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

All quality targets are being met.

f) Finance – Project cost

The project is proceeding according to the current projected cost plan, though pressures detailed separately for the Board may potentially result in an overspend. This potential overspend has increased proportionately from the position reported to the last Board meeting following revision of the project end date to 17th June 2022.

The key project outline is:

Project Start Date:	April 2020
Planned Completion Date:	June 2022
Contract Completion Date:	April 2022
Main Contractor:	Stanley Security Solutions Limited
Lead Advisor:	ThomsonGray
Programme Director:	Doug Irwin
Total Project Cost Projection (inc. VAT):	£10,517,113
Total costs to date (Inc. VAT) at 14th February 2022:	£ 9,447,084

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

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

Actual spend to date at 14th February 2022 is in line with the revised Stanley planned schedule of works.

Rounded breakdown of actual spend to date –

Stanley	£ 6.851m (Certified Value, 5% retention not applied)
Thomson Gray	£ 0.674m
Doig & Smith	£ 0.008m
HVM Design	£ 0.017m
VAT	£ 1.510m
Staff Costs	£ 0.387m
	£ 9.450m

4 RECOMMENDATION

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

MONITORING FORM

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

Paper No. 22/14

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	24 February 2022
Agenda Reference:	19
Sponsoring Director:	Chief Executive
Author:	Head of Corporate Planning and Business Support Clinical Effectiveness Team Leader Corporate Planning and Risk Project Support Officer
Title of Report:	Performance Report Q3 2021/2022
Purpose of Report:	To provide KPI data and information on performance management activities.

1. SITUATION

This report presents a high-level summary of organisational performance through the reporting of Key Performance Indicators (KPI's) for Q3: October – December 2021. Trend data is also provided to enable comparison with previous performance. The national standards directly relevant to the State Hospital are as follows: Psychological Therapies Waiting Times and Sickness Absence. Additional local Key Performance Indicators (KPIs) are reported to the Board and included in this report. Board planning and performance are monitored by Scottish Government through the Annual Operational Plan for 2020-21 which was submitted to Scottish Government to outline the priority areas of development.

The Board is asked to note that care continues to be delivered as outlined in the Interim Clinical Operational Policy (ICOP). This was introduced in March 2020 to ensure infection prevention and control measures are prioritized and is currently on version 23. The ICOP is supported by daily and weekly monitoring of key data to review the impact of the care model on the health and well-being of patients. This ensures that variations and trends are identified in a timely fashion and improvements made through multi-disciplinary discussion. The data gathered to inform decision making is listed below:

- Number of assaults/attempted assaults and verbal aggression
- Complaints and feedback
- Safe staffing
- Observation levels and seclusion
- Predictive data re violence and aggression
- Numbers of patients who cannot tolerate care in more isolated model
- Access to fresh air, physical activity and timetable sessions
- Participation in sessional activities such as those delivered by AHPs and Psychology.

2. BACKGROUND

Members receive quarterly updates on Key Performance Indicator (KPI) performance as well as an Annual Overview of performance and a Year-on-Year comparison each June.

3. ASSESSMENT

The following sections contain the KPI data for Q3 and highlight any areas for improvement in the next quarter through a deep dive analysis for KPI's that have miss their targets.

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

There was one KPI which improved this quarter although not enough to change its performance zone, this are:

- Patients will be offered an annual physical health review.

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

- Patients have their care and treatment plans reviewed at 6 monthly intervals.
- Patients will be offered an annual physical health review.
- Patients will undertake 90 minutes of exercise each week.
- Patients will have a healthier BMI.
- Sickness absence rate (National HEAT standard is 4%)

Performance Indicator	Target	RAG Q4 20/21	RAG Q1 21/22	RAG Q2 21/22	RAG Q3 21/22	Actual	Comment
Patients have their care and treatment plans reviewed at 6 monthly intervals	100%	A	A	A	A	92.96%	This indicator remains in the amber zone for quarter 3.
Patients will be engaged in psychological treatment	85%	G	G	G	G	82.79%	This indicator remains green for this quarter.
Patients will be engaged in off-hub activity centers	90%	-	-	-	-	-	This indicator was closed in June 2020 to accommodate engagement in off-hub activities during the pandemic.
Patients will be engaged in off-hub activity centers during COVID-19	90%	G	G	G	G	89.20%	This figure includes drop-in sessions which took place in hubs, grounds and the Skye Centre.
Patients will be offered an annual physical health review	90%	R	R	R	R	65.75%	Offering of annual health reviews recommenced in August 2021.
Patients will undertake 90 minutes of exercise each week	80%	R	G	G	A	70%	This indicator moves into the amber zone for quarter 3.
Patients will have a healthier BMI	25%	R	R	R	R	11%	The percentage of patients with a healthier BMI has remained the same in Q3.
Sickness absence rate (National HEAT standard is 4%)	** 5%	G	A	R	R	7.02%	October's figure was 6.66%, November's figure was 7.22% and December's figure was 7.20%.
Staff have an approved PDR	*80%	G	G	G	G	83.80%	This indicator has been within the green zone since March 2019.
Patients transferred/discharged using CPA	100%	G	G	G	G	100%	9 patients were transferred during this quarter all using CPA.
Patients requiring primary care services will have access within 48 hours	*100%	G	G	G	G	100%	This indicator remains 100% in Q3.
Patients will commence psychological therapies <18 weeks from referral date	**100%	G	G	G	G	97.00%	4 patients waited beyond the specified wait time during November and December 2021.
Patients have their clinical risk assessment reviewed annually.	100%	A	G	G	G	99.06%	As at 31 December 2021 there were 111 patients in the hospital. Five were new admissions. 3 patients in total had an out of date risk assessment.
Attendance at CPA Reviews (Refer to Appendix 1)							

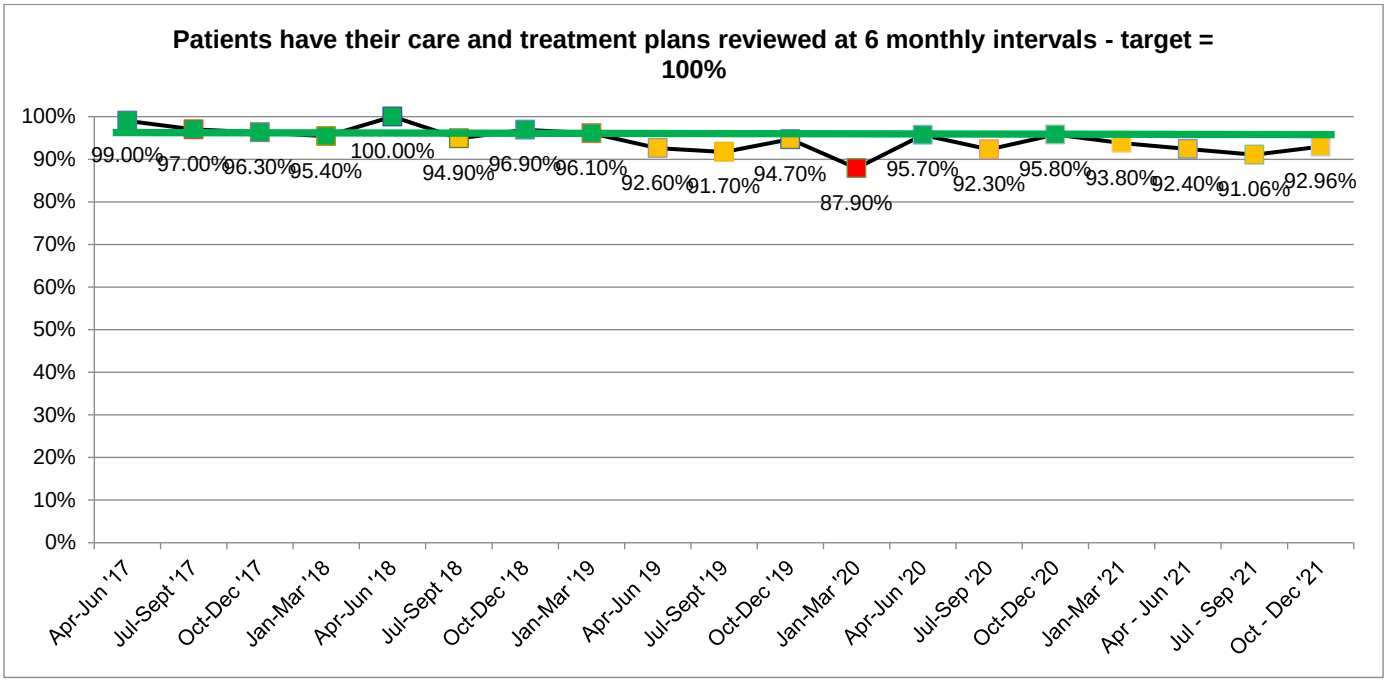
No 1: Patients Have their Care and Treatment Plans Reviewed at 6 Monthly Intervals

Target: 100%

Data for current quarter: 92.96%

Performance Zone: Amber

This is a Mental Health Act requirement for any patients within high secure settings. This indicator measures the assurance of patients receiving intermediate and annual case reviews. Care and Treatment Plans are reviewed by the multidisciplinary teams at case reviews and objectives are set for the next 6 months.



On 31 December 2021 there were 111 patients in the hospital. Five of these patients were in the admission phase. Seven CPA documents had not been reviewed within the 6-month period, or within the agreed admission phase. Five of these CPAs have been held with no documents being uploaded to RiO. Two CPAs have been scheduled but not yet held (more than 6 months after previous CPA).

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

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

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

Health Records staff continue to send reminder emails to RMOs and medical secretarial staff to advise that a patient's review or renewal of detention is due. The renewal of detention ties in with the annual CPA document being completed.

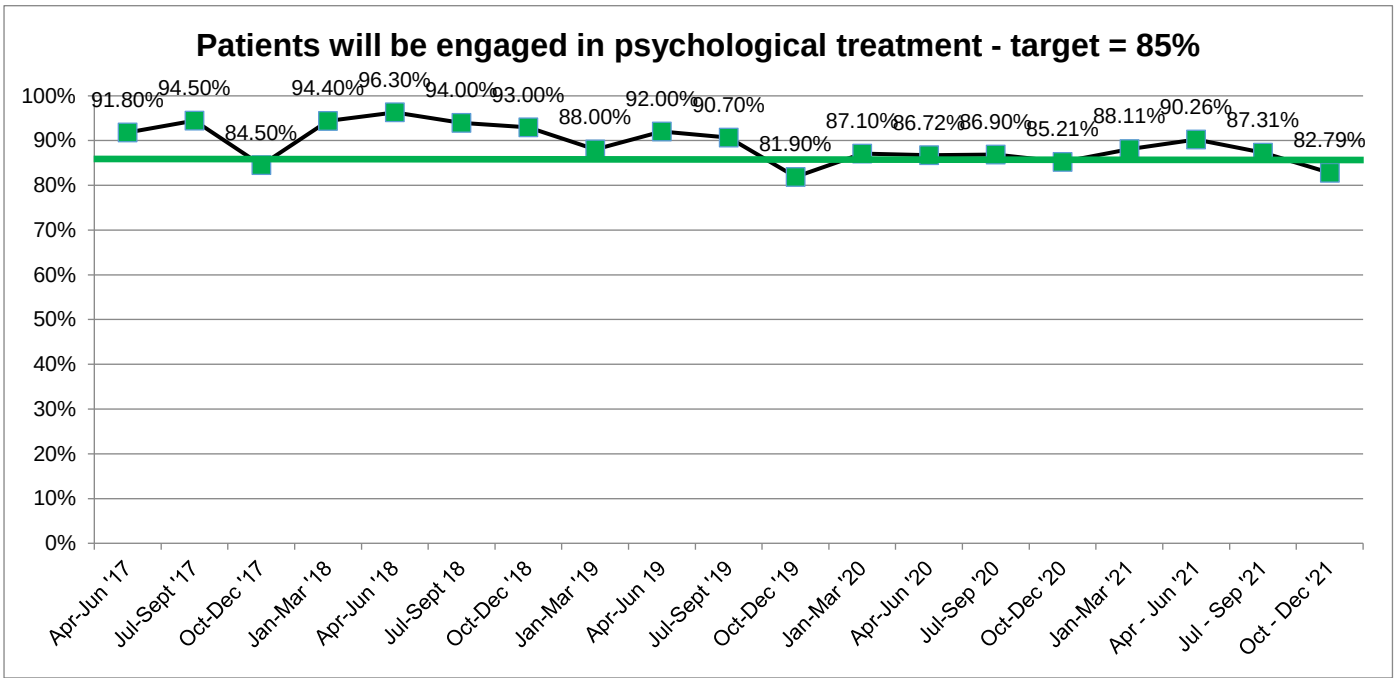
No 2: Patients will be Engaged in Psychological Treatment

Target: 85%

Data for current quarter: 82.79%

Performance Zone: Green

This indictor is a main priority of National Mental Health Indicators. This indicator measures the percentage of patients who are engaged and involved in psychological treatment.



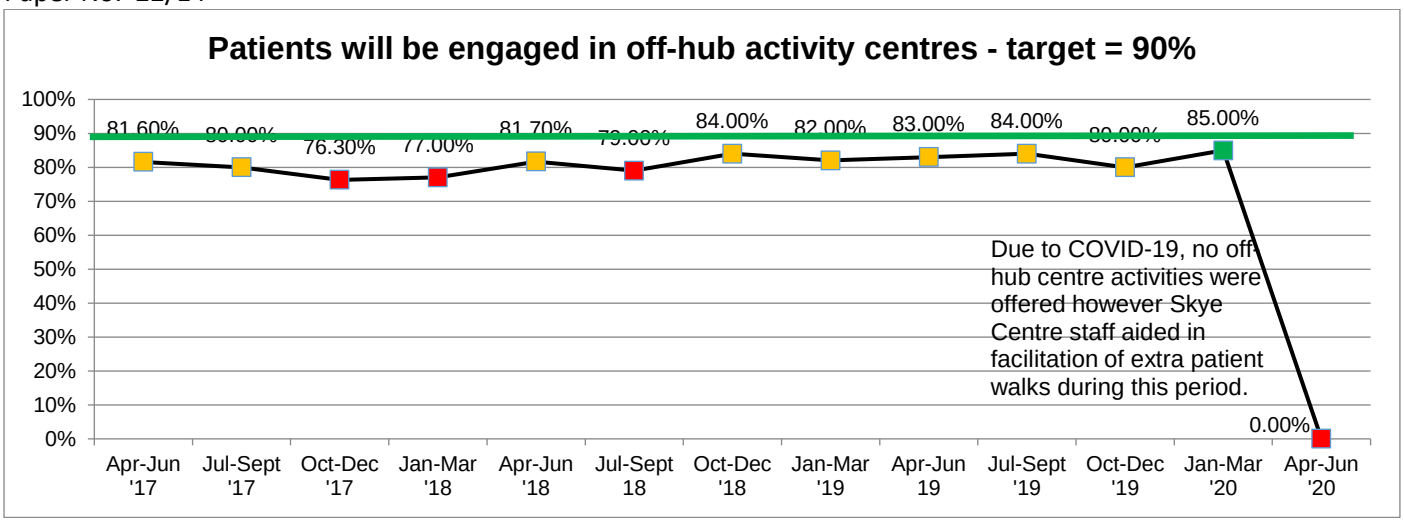
No 3: Patients will be Engaged in Off-Hub Activity Centres

Target: 90%

Data for current quarter: -

Performance Zone: -

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



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

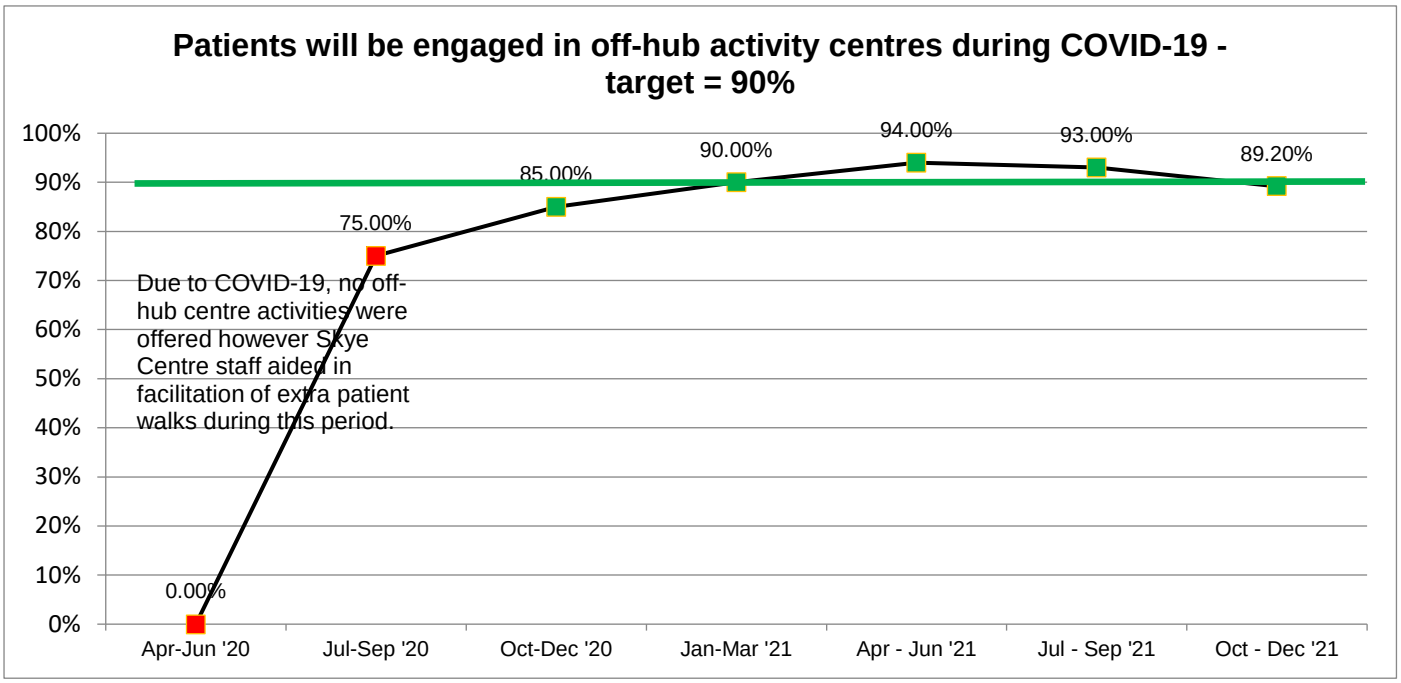
No 3.1: Patients will be Engaged in Off-Hub Activity Centers during COVID-19

Target: 90%

Data for current quarter: 89.20%

Performance Zone: Green

This measures the number of patients who are engaging in some form of timetable activity which takes place off their hub. The sessions may not necessarily directly relate to the objectives in their care plan however recognised as therapeutic activities. This will continue to be reported through the Operating Model Monitoring Group (OMMG).



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

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

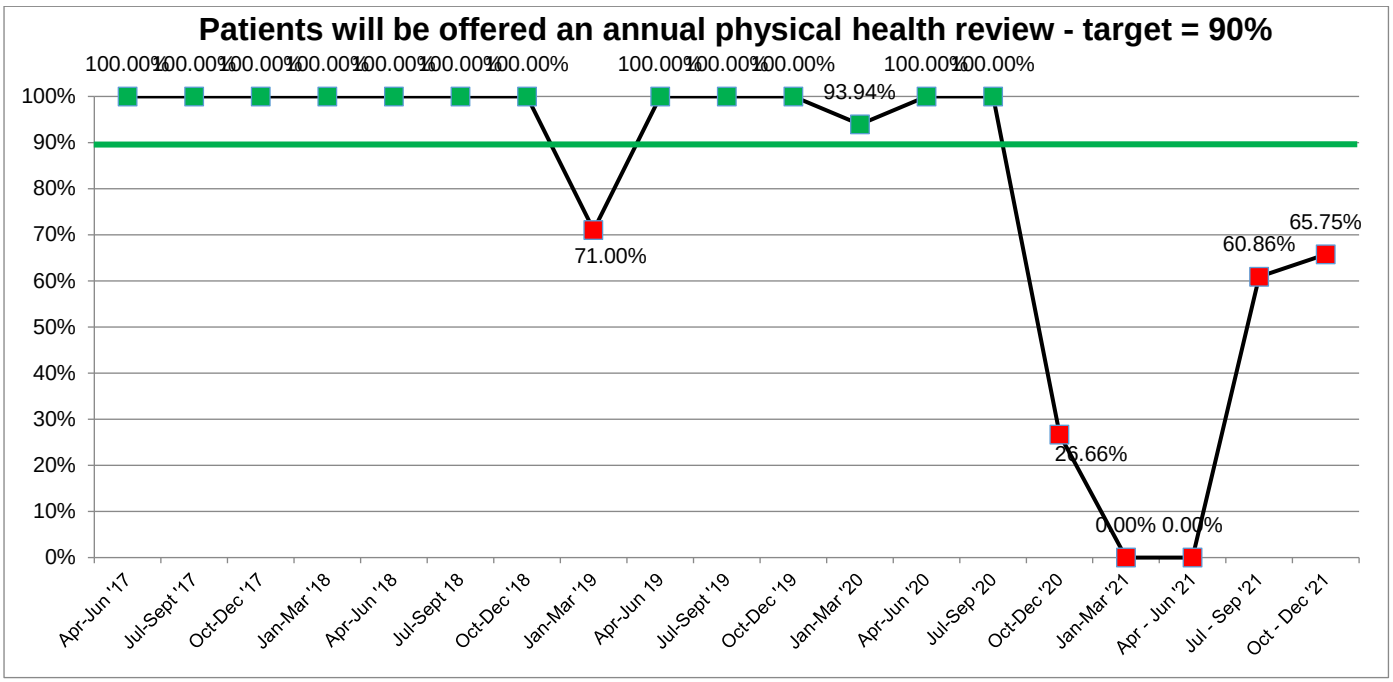
No 4: Patients will be Offered an Annual Physical Health Review

Target: 90%

Data for current quarter: 65.75%

Performance Zone: Red

This indicator is linked to the National Health and Social Care Standards produced by Healthcare Improvement Scotland (HIS). The indicator currently measures the offer of an annual health review and not the uptake. This is being reviewed to ensure that the KPI accurately captures physical health reviews carried out.



This indicator has risen again in Q3. A total of 32 patients were due their annual physical health review this quarter and 21 patients were offered this via a letter.

During this period, patients were, and still are, routinely receiving their annual bloods and ECG assessments in addition to the weekly support offered from the visiting Advanced Nurse Practitioner (ANP) for patients who required more regular assessment and intervention. Any physical health issues with our patients was actioned within 48 hours via the Health Centre and liaison with Junior Doctors during this period has been vital to ensuring that any personal physical issues / needs of our patients are met. In addition, onward outpatient referrals are still being sent through the Health Centre should there be any requirement beyond TSH capabilities, in conjunction with ANP visits. Locum Doctors from the Medwyn Practice were contacted for guidance during this period as the current GP for TSH is absent through long-term sick.

Work has progressed regarding the amendment of this KPI to reflect the uptake and quality of the physical health care provided. The Practice Nurse has liaised with the high secure estates in NHS England regarding their provision and procedure of offering an annual physical health review to all their patients. The Health Centre has devised a checklist template, benchmarked against the other high secure facilities, which will be completed for every patient when their annual review is due.

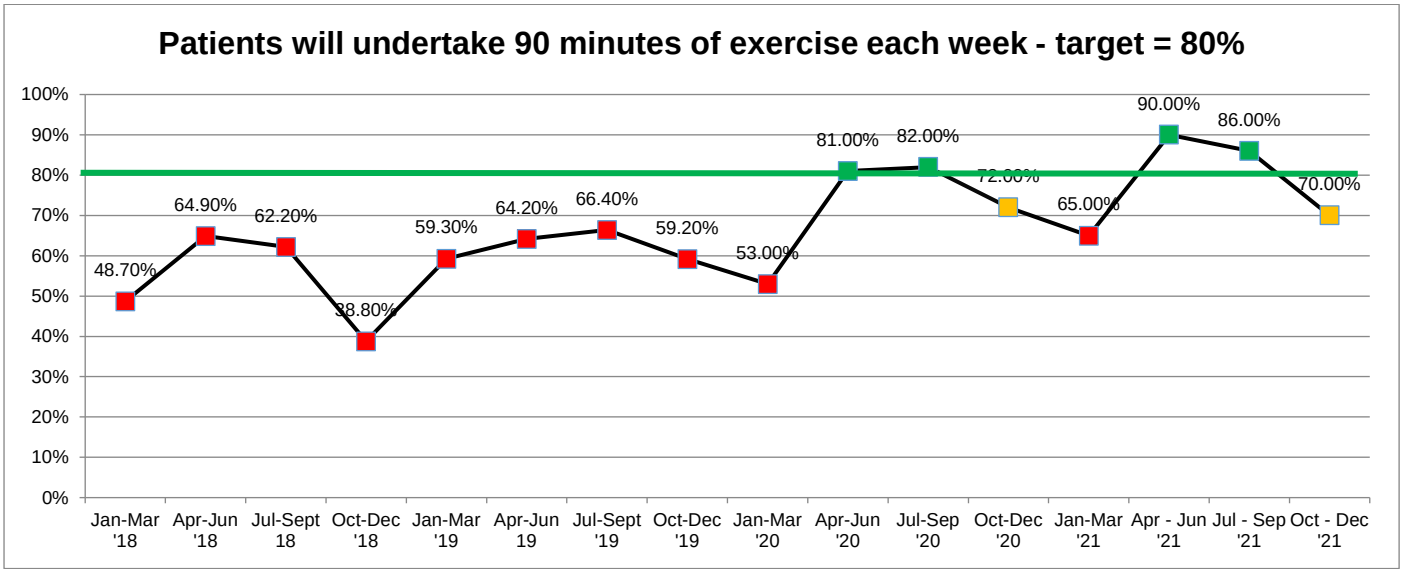
No 5: Patients will be Undertake 90 Minutes of Exercise Each Week

Target: 80%

Data for current quarter: 70%

Performance Zone: Amber

This links with national activity standards for Scotland. We acknowledge that the national standard is 150 minutes per week however, 90 minutes of exercise was chosen due to this being a challenging target for the hospital with the addition of an obesity issue within the patient group. This measures the number of patients who undertake 90 minutes of exercise each week.



Data recorded is patient participation in moderate physical activity intervention. This data includes patients participating in Sports and Fitness, Gardens, ward activities and escorted walks. This data also includes patients using Ground Access as a means of physical activity. Caution should be used to the data however, as this is based on patient self-reporting. This will continue to be reported through the Operating Model Monitoring Group (OMMG). Quarterly reporting is also provided to the Physical Health Steering Group (PHSG) who review the trend data and suggest possible ways of improving the uptake of Physical Activity.

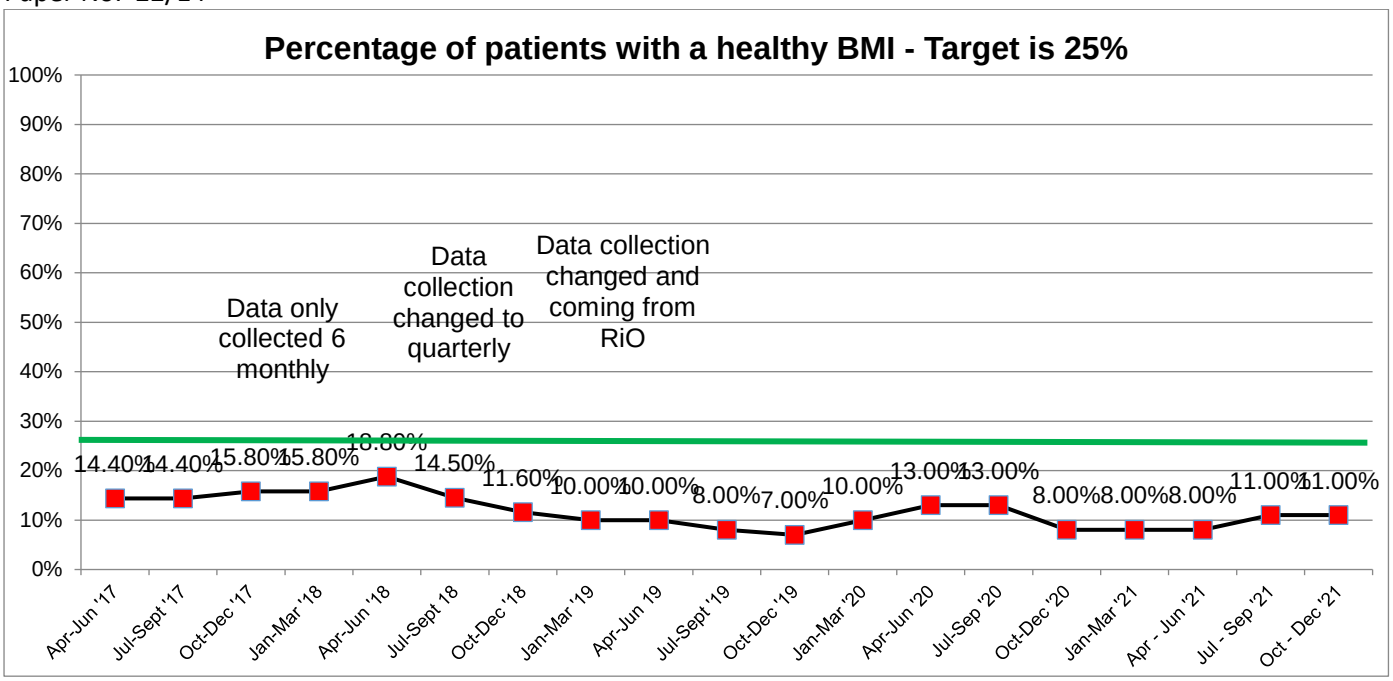
No 6: Patients will have a Healthy BMI

Target: 25%

Data for current quarter: 11%

Performance Zone: Red

This correlates towards the national target from the care standards as well as a corporate objective of TSH. This is an aspirational target and a local priority due to the obesity issue of our patient group.



The RiO reports show that 11% of patients have a healthy BMI; this remains the same figure as Q2. This indicator remains in the red zone. The data is a snap shot per month of the population, taken on the 12th of the month.

During this quarter, there was 14 instances where a patient had gained enough weight to move up a weight category and 13 patients who reduced in weight enough to move them down a weight category. 4 patients refused to have their weight taken during two months of this quarter. In quarter 3, there was 2 admissions; 1 was within the overweight range and 1 within Obese category 1 and 8 discharges; 3 who fell within the overweight range, 2 within the Obese 1 category and 3 within the Obese 2 category.

The PHSG have requested monthly monitoring reports to review the data and going forward, the Supporting Healthy Choices Group (SHCG) remits to change the culture in TSH for maximising physical activity and promoting healthier lifestyles; including dietary changes where appropriate. Options to consider how groups and ward-based weight loss interventions may be delivered have been included within the plan of work. The PHSG has requested monthly monitoring of Shop purchasing to ascertain the percentage of items purchased which fall in the healthy / unhealthy category and devise ways in which we can promote healthier purchases.

Weight Range BMI	**Q3 Oct-Dec 2021 N=107**	**Q2 Jul-Sep 2021 N=115**	**Q1 Apr-Jun 2021 N=112**	**Q4 Jan-Mar 2021 N= 96**
<18.5 Underweight	0%	0%	0%	0%
18.5-24.9 Healthy	11%	11%	8%	8%
25-29.9 Overweight	30%	33%	42%	40%
30-34.9 Obese (Class 1)	32%	33%	36%	34%
35-.39.9 Obese (Class 2)	19%	15%	12%	16%
>40 Obese (Class 3)	4%	4%	3%	2%

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

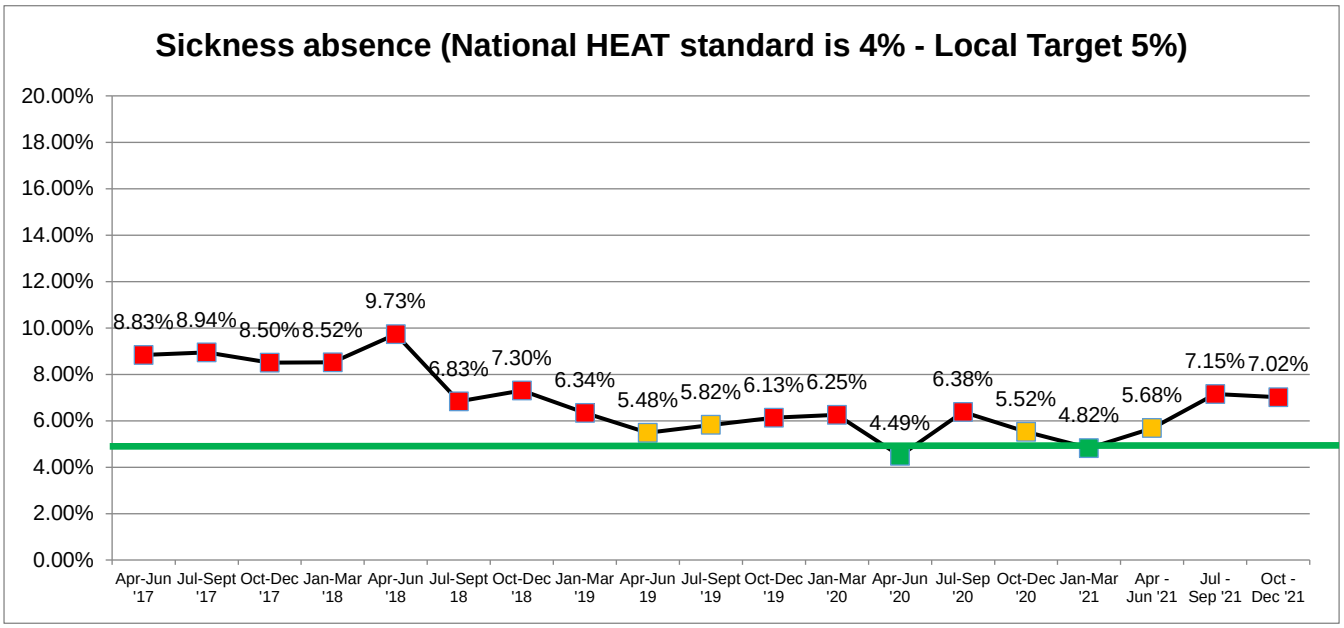
No 7: Sickness Absence (National Heat Standard is 4% - Local Standard Is 5%)

Target: 5%

Data for current quarter: 7.02%

Performance Zone: Red

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



Whilst Sickness Absence had increased, work continues on providing support to staff who are on long terms and short terms sick leave. HR Advisors are meeting with each of the Teams on a monthly basis to go over each case and provide additional support. Analysis has been undertaken with those on long term sick leave and it is clear that they are being supported by their Managers and Occupational Health. Further work is currently being done to ascertain if we need to provide additional support services in any particular key areas of concern. Anxiety / Stress and Depression continue to remain the highest reason for absence so consideration will be given to the support currently provided to staff and what the requirement is for the future.

The Health & Wellbeing agenda is also key to ensuring staff remain fit and healthy. A draft Wellbeing Strategy is currently out for consultation and this sets out the plans for the Board to support staff further with preventative solutions, where possible. The Wellbeing Advisors are working alongside staff and are speaking to them about the support and services that they would like to see and help with this moving forward.

COVID-19 RELATED SPECIAL LEAVE

It should be noted that in accordance with guidance set out in DL(2020)5 Coronavirus (Covid-19): National Arrangements for NHS Scotland Staff, staff absence and sickness related to Covid-19 is recorded as special leave and does not count towards sickness absence triggers. Details of working hours lost due to COVID-19 related special leave expressed by the monthly totals, are provided below.

Source: SSTS

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

Month	Hours Lost	Hours Lost %
October 2021	2336.34	2.39%
November 2021	2140.71	2.28%
December 2021	3229.11	3.33%

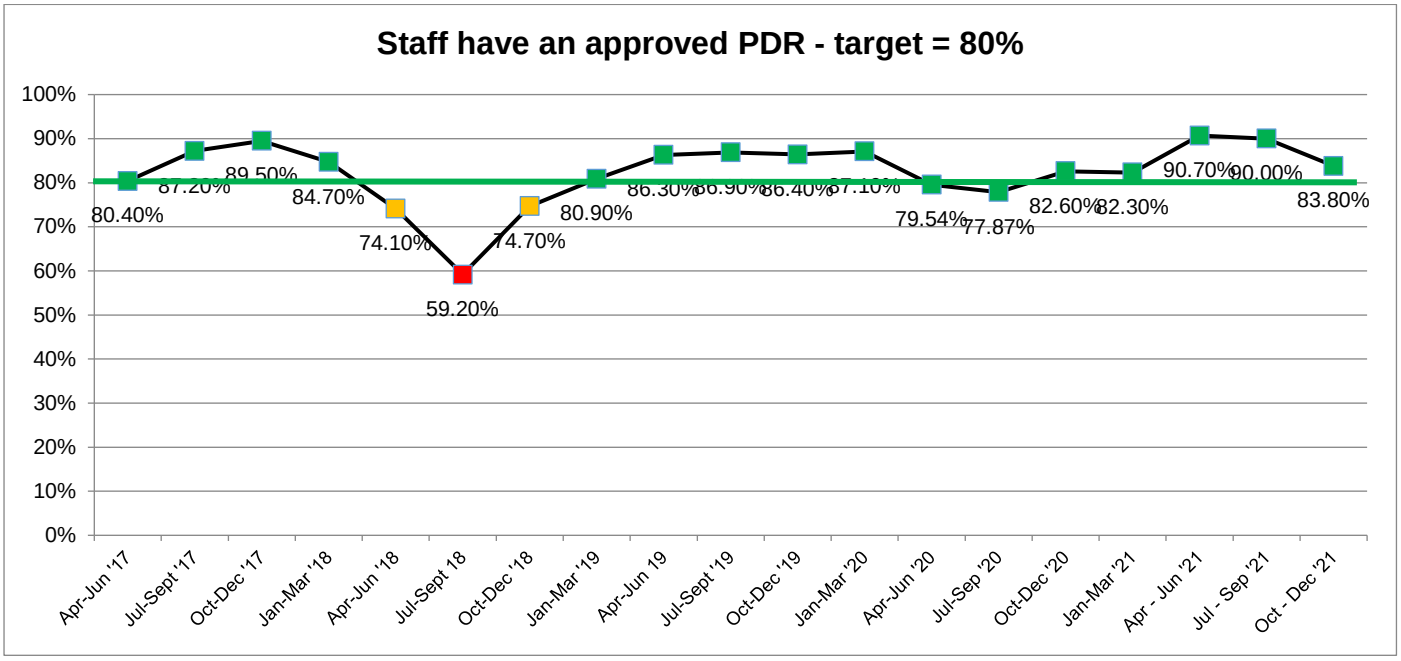
No 8: Staff have an Approved PDR

Target: 80%

Data for current quarter: 83.8%

Performance Zone: Green

This indicator relates to the National Workforce Standards; measuring the percentage of staff with a completed PDR within the previous 12 months.



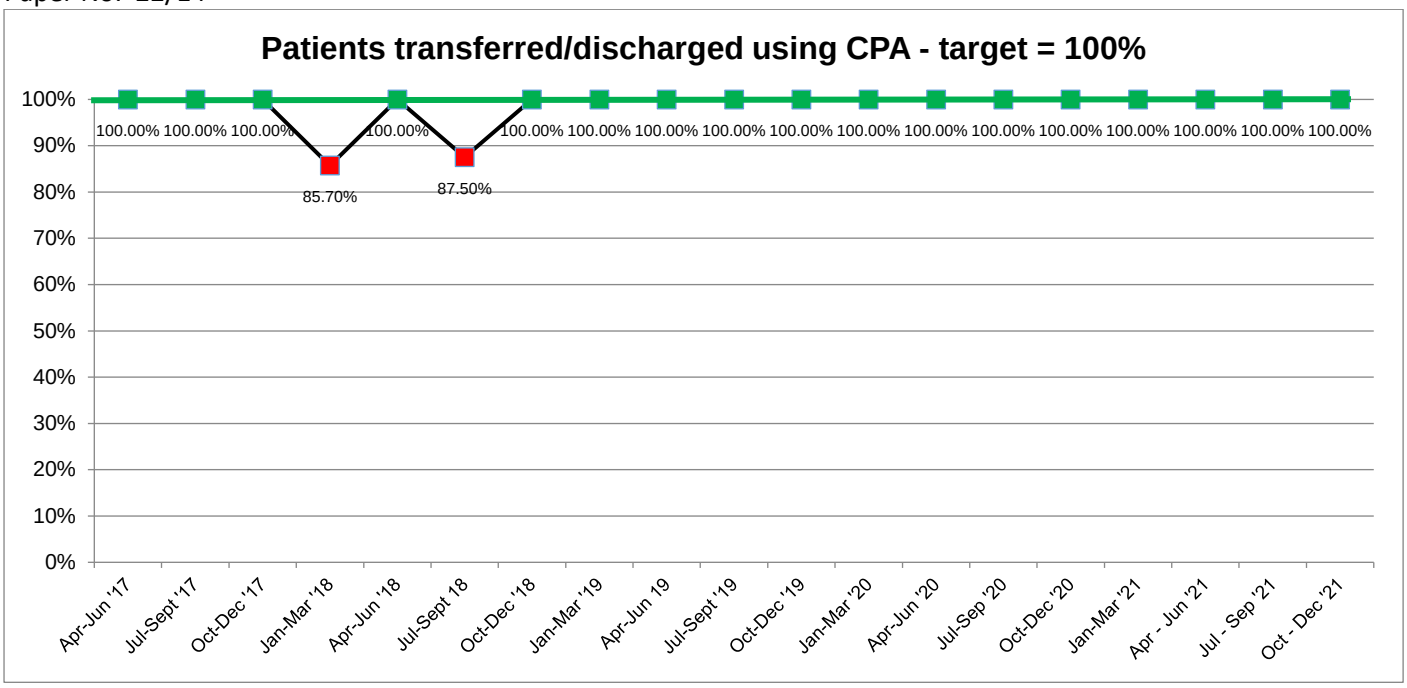
No 9: Patients are Transferred/Discharged using CPA

Target: 100%

Data for current quarter: 100%

Performance Zone: Green

The indicator is linked to the Mental Health Act, 2003 and the streamlining of discharges and transfers. The number of patients transferred out using CPA process are measured through this indicator.



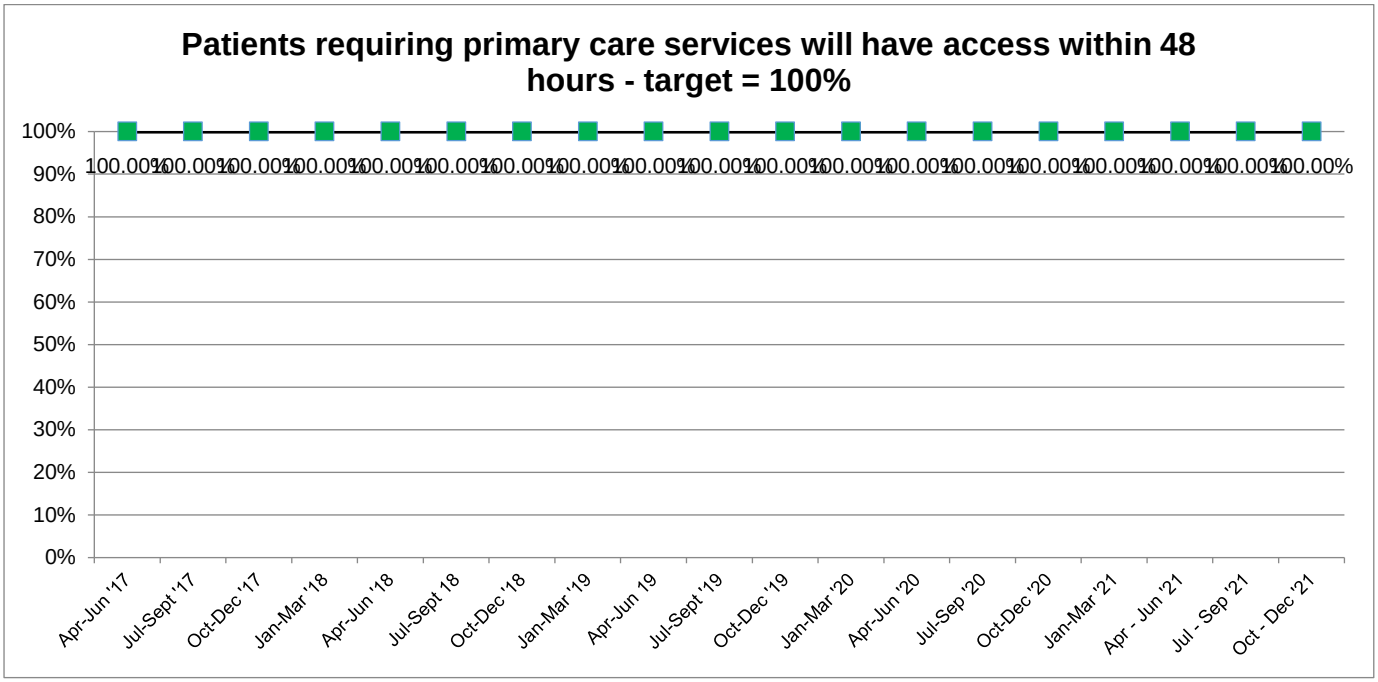
No 10: Patients Requiring Primary Care Services Will Have Access within 48 Hours

Target: 100%

Data for current quarter: 100%

Performance Zone: Green

This indicator is linked to National Health and Social Care Standards as published by Healthcare improvement Scotland (HIS). Primary care services include any service at our Health Centre including triage.



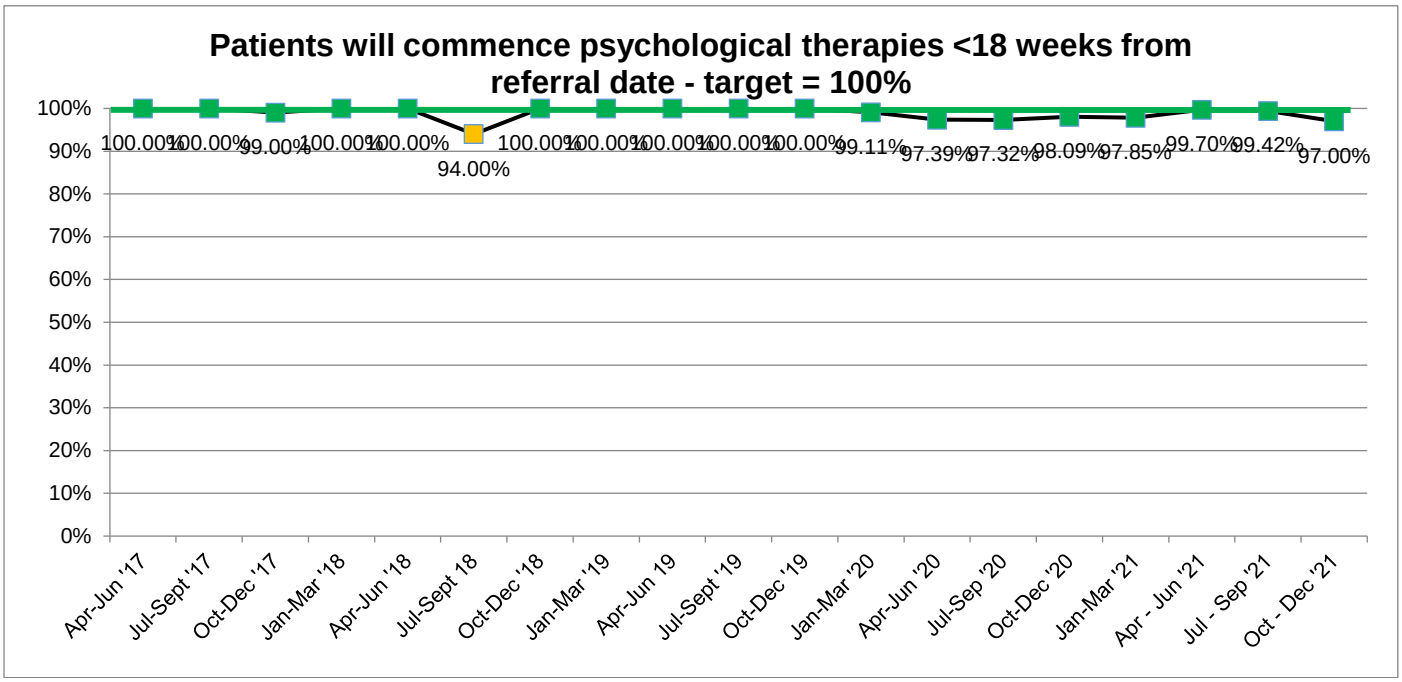
No 11: Patients will Commence Psychological Therapies <18 Weeks from Referral Date

Target: 100%

Data for current quarter: 97.00%

Performance Zone: Green

The indicator correlates to National Mental Health Indicators for Scotland to ensure that no patient waits more than 18 weeks to commence some form of psychological therapy.



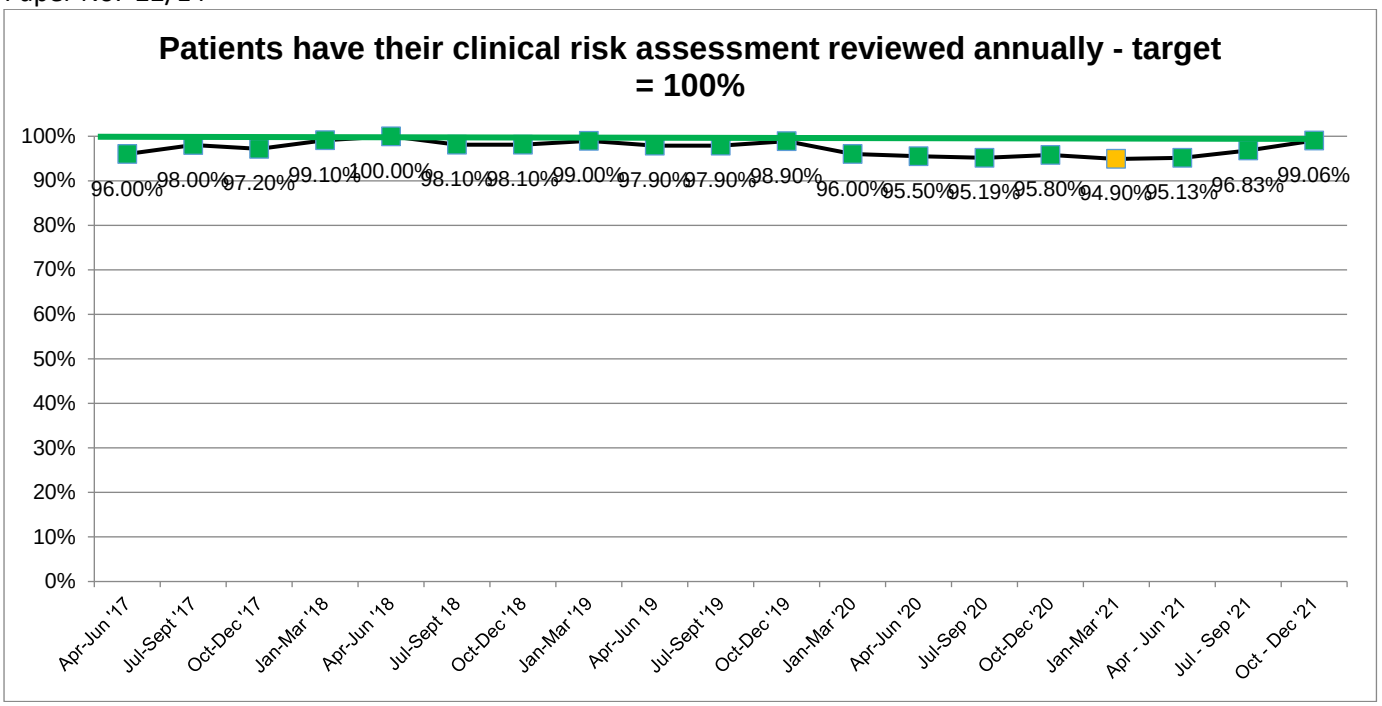
No 13: Patients have their Clinical Risk Assessment Reviewed Annually

Target: 100%

Data for current quarter: 99.06%

Performance Zone: Green

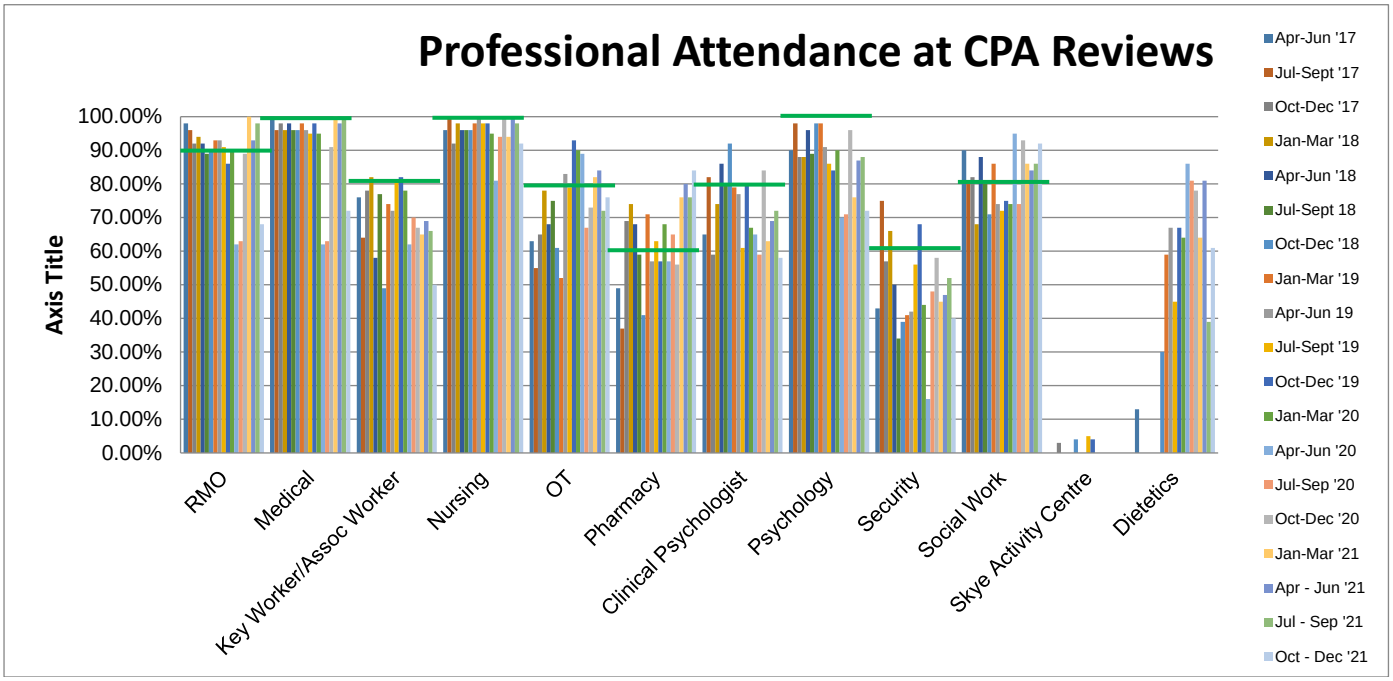
The indicator links with the Mental Health Care and Treatment Act Scotland, 2003. Examples of clinical risk assessments would be a HCR20 / SARA.



No 15: Professional Attendance at CPA Review

Target: Individual for each profession

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



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

RMO – attendance for this profession has declined to 68% in Q3. This indicator moves into the red zone. This comprised of 2 occasions where there was no RMO present and the Junior Doctor chaired in their stead and 14 instances of the VAT not being completed.

Medical – this profession moves in the red zone for this quarter, with a decline from 100% to 72% in Q3. This figure is due to lower percentage of VAT's being completed for this profession.

Key Worker/Associate Worker – attendance figures decreased to 50% in Q2 from 66% in Q1. This profession remains within the red zone. When a Key Worker/Associate Worker was unable to attend, a nursing representative attended in their place.

Nursing – during Q3, nursing attendance dipped to 92%; this profession moves into the amber zone.

OT – attendance has risen during Q3 to 76% from 72% in Q2. OT has moved into the green zone for this quarter.

Pharmacy – attendance for this quarter has risen from 76% to 84%. This profession has remained within the green zone since its data collection began.

Clinical Psychologists – this profession's attendance has decreased in Q3 to 58%. This indicator moves from the amber zone into the red for this quarter. 11 instances where the VAT form was not completed and a combination of annual leave, no reason, no outstanding need, other commitments and sickness absence made up this percentage.

Psychology – this professions attendance has declined in Q3 to 72%. This profession remains in the red zone. On 16 occasions where the Psychologist was unable to attend, a Psychology representative attended in their place and 11 instances where the VAT form was not completed contributed to this figure.

Security - attendance from security has decreased in this quarter from 52% to 40%. Security moves from the amber zone into the red for this quarter. 12 instances of staff off duty and 8 instances of no reason provided were the main contributing factors of this figure.

Social Work – attendance has slightly increased in Q3 to 92% from 86%. This profession remains in the green zone.

Dietetics – during Q3, attendance from dietetics has significantly increased to 61% from 39% in Q2. This can be attributed to a position being filled during October 21. There is no target for this profession as of yet.

4. RECOMMENDATION

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

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Monitoring of Key Performance Indicator Performance in the TSH Local Delivery Plan (2017-2020), the Operational Plan and the Remobilisation Plan submitted to Scottish Government in September, to cover the period September 20 – March 21.
Workforce Implications	No workforce implications - for information only.
Financial Implications	No financial implications - for information only.
Route to Board Which groups were involved in contributing to the paper and recommendations?	Corporate Management Team
Risk Assessment (Outline any significant risks and associated mitigation)	There is a dependency on the Business Intelligence project. While we can identify other ways of obtaining and analysing data there will be continue to be limitations on the timeliness and granularity of the information reported.
Assessment of Impact on Stakeholder Experience	The gaps in KPI data which make it difficult to assess.
Equality Impact Assessment	No implications identified.
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	n/a
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One √ There are no privacy implications. □ There are privacy implications, but full DPIA not needed □ There are privacy implications, full DPIA included.

Appendix 1

Item	Code	Principles	Performance Indicator	Profession (Lead)	Target	RAG Q2	RAG Q3	Overall attendance Oct – Dec 2021 (n=50)	Overall attendance Jul – Sep 2021 (n=50)	Overall attendance Apr – Jun 2021 (n=45)	Overall attendance Jan – Mar 2021 (n=49)
15	T	2, 6, 7, 9	Attendance by all clinical staff at case reviews	RMO **(LT)**	90%	G	R	68%	98%	93%	100%
				Medical **(LT)**	100%	G	R	72%	100%	98%	100%
				Key Worker/Assoc Worker **(MR)**	80%	R	R	50%	66%	69%	65%
				Nursing **(MR)**	100%	G	A	92%	98%	100%	94%
				OT**(MR)**	80%	A	G	76%	72%	84%	82%
				Pharmacy **(LT)**	60%	G	G	84%	76%	80%	76%
				Clinical Psychologist **(JM)**	80%	A	R	58%	72%	69%	63%
				Psychology **(JM)**	100%	R	R	72%	88%	87%	76%
				Security **(DW)**	60%	A	R	40%	52%	47%	45%
				Social Work **(KB)**	80%	G	G	92%	86%	84%	86%
				Skye Activity Centre **(MR)** (only attend annual reviews)	tbc			0%	0%	0%	0%
				Dietetics **(MR)** (only attend annual reviews)	tbc			61%	39% (n=19)	81% (n=16)	64% (n=25)

Definitions for red, amber and green zone:

- For all but item 6 and 7 green is 5% or less away from target, amber is between 5.1% and 10% away from target and Red will mean we are over 10% away from target
- For item 6: 'Patients have a healthier BMI' green will be 3% or less away from target, amber will be between 3.1% and 5% away from target and red will be over 5% away from target
- For 7 'Sickness absence' green is less than 0.5% from target, amber will be between 0.51% and 1% away from target and red will be over 1% and away from target

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	24 February 2022
Agenda Reference:	Item No: 21
Author(s):	Board Secretary
Title of Report:	Change to Chair – Remuneration Committee
Purpose of Report:	For Noting

1 SITUATION

The Board is asked to note an agreed change to the Chair of the Remuneration Committee.

2 BACKGROUND

National guidance and bench-marking to other NHS Boards, would suggest that re-consideration be given to the Board Chair acting as Chair of the Remuneration Committee due to the potential for a conflict of interests. This is in the context of the Board Chair's active involvement in the Executive and Senior Manager appraisal process.

3 ASSESSMENT

The Board Chair has a role in conducting the appraisal process for the Chief Executive, as well acting in the 'Grandparent' role for Executive Director appraisals which are conducted by the Chief Executive.

Given this active involvement, NHS Boards are asked to consider that this creates a potential conflict of interest, and that the Board Chair should not also be Chair of the Remuneration Committee.

Therefore, best practice would suggest that this role should be taken forward by another Non-Executive Director. Following discussion with the Board Chair, the Vice–Chair Mr McConnell has agreed to do so. This is in alignment with the view taken by other NHS Boards who are also taking forward this change in practice, if they have not already done so.

4 RECOMMENDATION

The Board is asked to:

- Note the change to Chair of Remuneration Committee as outlined.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	To support board business and scrutiny through its standing committee structure.
Workforce Implications	Not applicable
Financial Implications	Not applicable
Route To Board Which groups were involved in contributing to the paper and recommendations.	Board Secretary
Risk Assessment (Outline any significant risks and associated mitigation)	No specific risk assessment required as this ensures appropriate chair appointment to the committee structure
Assessment of Impact on Stakeholder Experience	No specific assessment of this required
Equality Impact Assessment	Not required
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	Not relevant
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One X There are no privacy implications. □ There are privacy implications, but full DPIA not needed □ There are privacy implications , full DPIA included.