THE STATE HOSPITALS BOARD FOR SCOTLAND

BOARD MEETING

THURSDAY 22 DECEMBER 2022
at 9.30 am, held by MS Teams
A G E N D A

9.30am			
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 27 October 2022	For Approval	TSH(M)22/09
4.	**Matters Arising:**		
	Actions List: Updates	For Noting	Paper No. 22/109
5.	**Chair's Report**	For Noting	Verbal
6.	**Chief Executive Officer's Report**	For Noting	Verbal
10 am	**RISK AND RESILIENCE**		
7.	**Corporate Risk Register** Report by the Director of Security, Resilience and Estates	For Decision	Paper No. 22/110
8.	**Operational Response Plan – Update** Report by the Director of Nursing and Operations	For Noting	Paper No. 22/111
9.	**Infection Prevention and Control Report** Report by the Director of Nursing and Operations	For Noting	Paper No. 22/112
10.	**Bed Capacity Report:** **The State Hospital and Forensic Network** Report by the Medical Director	For Noting	Paper No. 22/113
10.30am	**** BREAK****		
11.15pm	**CLINICAL GOVERNANCE**		
11.	**My Volunteer Journey Across the Forensic Network** Introduced by the Director of Nursing and Operations	For Noting	Presentation
12.	**Patient Advocacy Service: 12 Month Report** Introduced by the Director of Nursing and Operations	For Noting	Paper No. 22/114
13.	**Clinical Model Implementation – Update** Report by the Medical Director	For Noting	Paper No. 22/115

14.	**Quality Assurance and Quality Improvement** Report by the Head of Planning and Performance	For Noting	Paper No. 22/116
15.	**Clinical Governance Committee:** - Chair's Update – meeting held 10 November 2022 - Approved minutes of meeting held 11 August 2022	For Noting	 Verbal CGC(M) 22/03
16.	**Clinical Forum** - Chair's Update – meeting held 29 November 2022 - Approved minutes of meeting held 20 September 2022	For Noting	 Verbal CF(M) 22/03
12.05pm	**STAFF GOVERNANCE**		
17.	**Workforce Report** Report by the Director of Workforce	For Noting	Paper No. 22/117
18.	**Whistleblowing Quarter 2 Report** Report by the Director of Workforce	For Noting	Paper No. 22/118
19.	**Staff Governance Committee** - Chair's Update – meeting held 17 November 2022 - Approved minutes of meeting held 18 August 2022		 Verbal SGC (M) 22/03
12.20pm	**CORPORATE GOVERNANCE**		
20.	**Corporate Governance Improvement Action Plan** Report by the Board Secretary	For Decision	Paper No. 22/119
21.	**Board Workplan 2023** Report by the Board Secretary	For Decision	Paper No. 22/120
22.	**Finance Report to 30 November 2022** Report by the Director of Finance & eHealth	For Noting	Paper No. 22/121
23.	**Performance Report – Quarter 2** Report by the Head of Planning and Performance	For Noting	Paper No. 22/122
24.	**Sustainable Centralised Visiting – Update** Report by the Director of Security, Resilience and Estates	For Noting	Paper No. 22/123
25.	**Perimeter Security and Enhanced Internal Security Systems Project** Report by the Director of Security, Resilience and Estates	For Noting	Paper No. 22/124
26.	**Audit Committee:** - Chair's Update – meeting held 29 September 2022		 Verbal
27.	**Any Other Business**		Verbal
28.	**Date of next meeting**		Verbal

29.	**Proposal to move into Private Session, to be agreed in accordance with Standing Orders.** Chair	For Approval	Verbal
	Close of Session and Reflection on Meeting		Verbal

Estimated end at 1pm

THE STATE HOSPITALS BOARD FOR SCOTLAND **TSH (M) 22/09**

Minutes of the meeting of The State Hospitals Board for Scotland held on Thursday 27 October 2022.

This meeting was conducted virtually by way of MS Teams, and commenced at 9.30am.

Chair: Brian Moore

Present:

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

In attendance:

Director of Workforce	Linda McGovern
Head of Social Work	David Hamilton
Chair of Clinical Forum	Sheila Howitt
Information Governance and Data Security Officer	Ken Lawton [Item 24]
Head of Planning and Performance	Monica Merson
Head of Communications	Caroline McCarron
Board Secretary	Margaret Smith [Minutes]
Director of Security, Resilience and Estates	David Walker

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

Mr Moore welcomed everyone to the meeting, and it was noted that there were no apologies.

2 CONFLICTS OF INTEREST

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

3 MINUTES OF THE PREVIOUS MEETING

The Minutes of the previous meeting held on 25 August 2022 were noted to be an accurate record of the meeting.

The Board:

1. Approved the minute of the meeting held on 25 August 2022.

4 ACTION POINTS AND MATTERS ARISING FROM PREVIOUS MEETING

The Board received the action list (Paper No. 22/ 83) outlining progress and confirming that updates that would be presented during the course of this meeting. It was also noted as a matter arising that potential winter pressures and associated risks to service delivery would be discussed as part of the meeting agenda.

The Board:

1. Noted the updated action list, and confirmed it as being accurate.

5 CHAIR'S REPORT

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

He had taken part in two Quality and Safety Walkrounds within the hospital, visiting Mull Hub as well as the Skye Centre and these visits had been helpful and informative. Mr Moore had also attended the Patient Partnership Group, and this had provided an excellent opportunity to hear directly from patients especially in respect of the new Clinical Model. He also attended the Clinical Forum to provide an update on Board activity.

Mr Moore advised that the Board had held a Board Development Session on 1 September, and that this had included a presentation and discussion with Ms Rosemary Agnew in her role as Independent National Whistleblowing Officer (INWO). In addition, the Board had received an interesting and informative presentation from Dr Jana de Villiers, Clinical Lead for Intellectual Disabilities on this particular area of patient care. The Board had had also taken part in the first of two dedicated sessions with internal auditors focusing on risk reporting, and how the Board assesses its own risk appetite.

More widely in terms of whistleblowing, Mr Moore noted the success of "Speak Up Week" in raising awareness across the organisation. He advised that following a recruitment process, it was expected that an appointment would be made for the State Hospital (TSH) Non-Executive Whistleblowing Champion very shortly.

Mr Moore advised that he had taken part in NHS Scotland Chairs meetings and Away Days, and that focus nationally remained on winter pressures and strengthening collaborative working, as well as financial constraints. The additional pressure of pay settlement for Agenda for Change (AFC) staff across NHS Scotland was of particular focus presently. The Chair also advised that there had been discussions on developing the workforce of the future, new roles, the workforce plan, staff wellbeing, and a report on the diversity of Board members in terms of the changes that have taken place over recent years.

He also acknowledged the National Care Service Bill, currently going through the legislative process, and the relevance this could have for the future model of forensic services. Lastly, he provided an update on the visit to TSH by the Director-General of Health and Social Care and CEO of NHS Scotland, Ms Caroline Lamb, as well as Mr John Burn, Chief Operating Officer. This had enabled them to meet both staff and patients as well as Board members, and see first-hand the excellent facilities the hospital provided.

The Board:

1. Noted this update from the Chair.

6 CHIEF EXECUTIVE'S REPORT

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

Firstly, he echoed the Chair's words around the visit by Ms Lamb and Mr Burns as well as other colleagues from the Mental Health Directorate. He expressed thanks to all the staff who had involved in the visit. Mr Jenkins noted that the Mental Welfare Commission carried out inspections visits in September and October with positive verbal feedback received, and the formal report awaited. He also advised that HM Chief Inspector of Prisons, Ms Sinclair-Gieben, had visited TSH to see the therapeutic approach taken to seclusion within TSH. She had found the visit extremely helpful, and this had led to an approach from HMP Glasgow to also visit to look at the model of care provided within TSH.

Mr Jenkins advised that the Shared Intelligence for Health & Care Group would be holding a feedback session with the TSH leadership team on 31 October. This process took place annually, led by Healthcare Improvement Scotland (HIS). Mr Jenkins would share the feedback received to date from them with the Board. He also advised that in line with all other NHS Boards in Scotland, the Information Commissioner's Office (UK) would be undertaking an audit of TSH of information governance practice and processes.

Mr Jenkins was pleased to confirm that the regular schedule of bi-monthly meetings continued to take place with the Patients' Advocacy Service, with himself and the Director of Nursing and Operations, to triangulate intelligence and feedback and support patients. The Project Manager for the Supporting Healthy Choices workstream had been appointed, to enable continued focus in this area. A new facility for patients in the form of a 'Nu2U' Charity Shop would be opening in November.

Mr Jenkins confirmed that Ms Merson had led on the submission of the Winter Preparedness Checklist to the Scottish Government outlining the actions planned over the winter months to support resilience.

Recruitment to the nursing workforce continued to be of paramount importance. In this respect, a further temporary skill mix adjustment had been agreed, in partnership, following some very impressive Healthcare Support Workers candidates. This was positive in bringing on board additional staff, and the transition back to the usual skill mix would now be carefully managed.

Mr Jenkins provided assurance that work had been progressed in partnership to prepare for the possibility of industrial action during the course of the winter given the lack of agreement to date on the AFC pay negotiations.

Following this update, Mr Currie commented that it was very positive to learn of the wider links being established both as part of NHS Scotland as well as the public sector in general. There was also discussion on the potential of industrial action in the context of ongoing uncertainty in pay negotiations. It was noted to be reassuring that local resilience planning was advanced. Mr Moore summed up for the Board, including all the local initiatives taking place as well as links being made regionally and nationally.

The Board:

1. Noted the update from the Chief Executive.

RISK AND RESILIENCE

7 CORPORATE RISK REGISTER

The Board received a paper (Paper No. 22/84) from the Director of Security, Resilience and Estates, which provided an overview of the medium, high and very high risks featuring on the Corporate Risk Register

Mr Walker presented an overview of the report and provided assurance that each risk was being assessed and appropriate control measures put in place. He confirmed that all risks rated as 'High" were reviewed monthly by the risk owners. He highlighted that SD 54 - Implementing Sustainable

Development in Response to the Global Climate Emergency - had been reviewed through the Climate Change and Sustainability Group, and updated to ensure it aligned with the nationally led policy. Further, that a new risk was under development - CE15 - relating to the impact of the two simultaneous Public Inquiries into the response to Covid-19. Mr Walker asked the Board to note the change to the format of the report to differentiate between risks according to their risk level.

Mr Currie asked for further clarity on risk HRD111 – Deliberate Leaks of Information in that it was graded as being a medium risk. He also placed this in a wider context as to why such a leak may occur in that this may be due to staff feeling that they should highlight what they perceive to be a risk or failure within the organisation. He noted that it may be helpful for the Board to consider all aspects around the potential reasons for this to occur. Mr Jenkins agreed with the validity of this and that this should be part of the assessment of this risk to ensure any possible learning, as well as regular assessment of the risk level.

Mr McConnell underlined that the refinements made to the report were helpful, and asked for confirmation that movements in risk gradings were being monitored, including those risks that may be considered to have worsened from the current rating i.e. by moving the target rating to align with that. Mr Walker confirmed that this was the case with the Risk Team monitoring this process with risk owners.

Mr Moore summed up for the Board in noting that the Board accepted the recommendations in the paper. He underlined that it was positive to see this work progressing and offered the Board's thanks to the Risk Team.

The Board:

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

8 OPERATIONAL RESPONSE PLAN

The Board received a paper (Paper No. 22/85) from the Director of Nursing and Operations, which provided an update in relation to the operational response to potential loss of staffing impacting significantly on the delivery of care.

Ms McCaffrey provided a summary of the report, emphasising that this was continuing to be developed by taking into account the learning from the Covid-19 experience, and the Loss of Staff Plan originally developed. She wished to provide the Board with assurance that this was so that continued improvement could be made building on the measures already in place, which provided clear structure for decision-making, and escalation as appropriate.

This paper was welcomed by the Board, and it was agreed that this gave continued assurance on operational resilience. Mr Currie asked if this was being developed in alignment with Health and Social Care Safe staffing legislation, and Ms McCaffrey confirmed that this was the case, and a clear focus. Mr Jenkins added that the development process for this would define the escalation process, and relevant trigger points through targeted metrics i.e. a process connected to safe staffing which would identify when this became a risk. There should also be a process to ensure that the Board was alerted, should this risk become significant, so that they had oversight of the risk.

There as further discussion on how modified working arrangements were defined, and Ms McCaffrey provided further clarity on the restrictions that may be put in place and how these were applied consistently across the organisation to ensure that the impact on patients was minimised as much as possible.

Mr Moore noted that this was a key report in terms of governance and to give transparency on decision-making, and that the Board would receive a further update in respect of the relevant escalation process and how this would be taken forward.

Action – Ms McCaffrey

The Board:

1. Noted the content of the paper.
2. Requested further update on escalation process and link to safe staffing legislation

9 INFECTION PREVENTION AND CONTROL REPORT (INCORPORATING COVID-19 UPDATE)

The Board received a paper (Paper No. 22/86) from the Director of Nursing and Operations, which provided an update in relation to Hospital Acquired Infection (HAI) activity including Covid-19. Ms McCaffrey presented this report and provided a summary of the key points around infection prevention and control activity, as well as safe Covid-19 practice. She emphasised that this should be considered as business as usual in terms of infection prevention and control.

Mr Currie welcomed the improvement in hand hygiene compliance, and added that it would be important to avoid unforced errors like the adherence to control measures that were within the organisation's control such as mask wearing. He raised the issue of how to ensure that all staff understood the importance of this going into the winter period. There was agreement around the table that the areas of lack of compliance (e.g. wearing of nail varnish) and the need to improve in these areas. Ms McCaffrey offered assurance that this was very much the focus of the Infection Control Group, which met monthly, and the need for all staff to understand their individual responsibility to meet all standards.

Ms Radage added that this was a helpful report, which gave an unvarnished update of the position. She asked if the patient uptake on vaccination was comparable to some hesitancy evidenced across society as a whole. Mr McConnell agreed with these points underlining possible fatigue and familiarity with vaccination process may be a contributing factor. Professor Thomson advised that there had been an increase in the number of patients declining the booster vaccination for Covid-19. Every patient had been approached by their Responsible Medical Officer to discuss their needs. Following this process, it was Professor Thomson's intention to then write to any patient who had continue to decline vaccination to make sure that they were aware of the relevant risks, and to offer them support. Professor Thomson also added that it was important to recall that the current protocol on not isolating whole wards when an individual patient contracted Covid-19 (but rather the affected patient) may have to be reviewed if vaccination levels within the patient population did not improve as a whole.

Mr Moore summed up for the Board, to note the content of the update.

The Board:

1. Noted the content of report.

10 BED CAPACITY IN THE STATE HOSPITAL AND FORENSIC NETWORK

The Board received a paper (Paper No. 22/87) from the Medical Director, which detailed the actions taken to monitor the bed capacity within TSH within the context of the wider Forensic Network. Professor Thomson outlined the key points, including a summary of the data for the months of August and September, as well as a copy of the bed report for the wider forensic estate, which was produced weekly (this report dated 3 October 2022). She highlighted that there were currently 16 patients, within TSH, who had been assessed as being ready for transfer.

The Board noted the helpfulness of this report, and that it helped to demonstrate the movement of patients from TSH to lower levels of security within the forensic estate, when considered appropriate in their care journey, as well as the current pressures within the system.

The Board:

1. Noted the content of report.

CLINICAL GOVERNANCE

11 CLINICAL MODEL IMPLEMENTATION

The Board received a paper (Paper No. 22/88) from the Medical Director, to provide an overview of the progress made on the implementation of the new clinical model within TSH. Professor Thomson introduced this paper, and advised that implementation of the model was included on the agenda of the next Clinical Governance Committee meeting taking place on 10 November, to support detailed oversight.

Ms Merson then summarised the key aspects for the Board, highlighting that the Project Oversight Board and the Project Short Life Working Group (SLWG) were both now in place, as well as the project team. She drew attention to the project plan and the flash reporting provided. Ms Merson advised that focus was on the development of clinical guidance as the crucial next step in the implementation process, with a working group attached to each clinical specialty. She also highlighted the communications activity to support the project as being a fundamental strand of activity.

Ms Fallon asked if there had been any key points to date arising from the SLWG, and Professor Thomson confirmed that the group had wide-ranging discussions on the new model. She highlighted that it should be recognised that the delay in implementation of the model, had meant that there had been natural turnover in the staff involved. Therefore, those now taking this forward had not necessarily been in post at the time the model had been originally been developed through an options appraisal process. There had also been uncertainty as to the timing of the re-start of implementation over the past two years given the extended impacts of the Covid-19 pandemic, and this had led to heightened anxiety for some staff. The model implementation was now very real and imminent. Professor Thomson advised that it had been helpful to begin this process now by highlighting that the model had been developed with the purpose of supporting progression for patients in their care journey. Ms Merson added that the project team had undertaken extensive supportive work in ensuring that all those now involved had access to the previous options appraisal reporting so that they were able to take a well-informed approach to the implementation plan. Dr Howitt added her agreement that this was a helpful approach, and that the SLWG were able to be reactive to any issues arising through the process.

Mr Moore commented that it was important to recognise the way in which staff had to adjust to the delays experienced due to the pandemic, and the way in which implementation had now become very real and represented significant change in the organisation. He noted that it was essential to capture concerns that may arise so that these could be addressed as the implementation process continued.

<u>The Board:</u>

1. Noted the content of this update.
2. Agreed that the Board should receive further regular update reporting.

12 QUALITY ASSURANCE AND QUALITY IMPROVEMENT

The Board received a paper from the Head of Planning and Performance (Paper No. 22/89) which provided update reporting on progress made towards quality assurance and improvement activities since the date of the last Board meeting. Ms Merson presented the report, summarising the key workstreams including clinical audit and variance analysis tools and the development of the Activity Oversight Group through an evidence based approach. She also outlined the continued work of the Quality Forum and capacity building for Quality Improvement, as well as an update on the Realistic Medicine workstream and evidence for quality assessment.

Ms Fallon asked for clarity on several points, and there followed discussion around the table. Firstly, in respect of the issues evidenced by the PMVA Observation Policy Audit around communication. Ms Merson noted that this did appear to be more a matter of lack of record keeping rather than lack of

communication, and that this was an area that required improvement. The reviewed form would include a section for carers to be able to provide comment. Ms McCaffrey also provided assurance that this was an opportunity to take learning from this. In relation to the PMVA Post Physical Intervention Policy, Ms McCaffrey also confirmed that the poster referred to was not placed in patient areas, and the focus remained on improvement in this area and how to follow best practice. These areas would continue to be of focus for the Patient Safety Group.

In relation to how shared decision-making could be taken forward especially through the new clinical model framework, Professor Thomson underlined the importance of this within TSH, and placed this within the context of the legal framework of restriction. At the same time, the majority of patients did have capacity to take decisions so it was essential to ensure that they were well informed and actively involved in their own care. The framework for this was through the Care Programme Approach (CPA) to support patients to internalise and buy in to their treatment plan. Each patient would have two meetings annually, and these try to involve those patients who were able to attend, with attendance rates currently 77%. Ms Merson also noted that this would be built into the clinical guidance documents being prepared for the new clinical model.

There was also discussion of terminology used in reporting to the Activity Oversight Group (AOG) defining "pacing" as part of patients' physical activity. Ms McCaffrey advised that this would be in relation to patients unable to exercise outside of ward areas, but that the AOG were seeking a change in the terminology, and that an update on this would be brought back to the Board.

Action - Ms McCaffrey

Mr Moore commented on the positive nature of the clinic audit work, Further that this report was helpful and continued to provide the Board with a wide-ranging summary of the quality assessment and improvement workstreams being progressed.

The Board:

1. Noted the content the report and updates contained therein.

13 MEDICAL APPRAISAL AND REVALIDATION ANNUAL REPORT

The Board received a paper (Paper No. 22/90) from the Medical Director to provide annual reporting on Medical Appraisal and Revalidation within TSH during 2021/22. Professor Thomson presented this paper to the Board, confirming that during this time period all medics had undergone annual appraisal as well as the revalidation process as appropriate. Further, that policy guidance within TSH was regularly reviewed and aligned to national arrangements. The Board was content to note this update.

The Board:

1. Noted the content the report and updates contained therein.

14 MEDICAL EDUCATION REPORT

The Board received a paper (Paper No. 22/91) from the Medical Director, which detailed reporting on the arrangements for medical education at TSH for the period 1 August 2021 until 31 July 2022. Professor Thomson presented a summary of the paper, in relation to the activity undertaken for both undergraduate and postgraduate education to give an excellent standard of meaningful training. She placed this in the context of the continued impacts of the pandemic during this time period and the moves towards more normal ways of working. She drew the Board's attention to the difficulties experienced for Specialty Trainee Doctors from the North of Scotland in terms of the geographical challenge of planning on call; and assurance that this was being highlighted nationally and progress being sought to resolve this going forward. Professor Thomson also emphasised the work being done to support future recruitment, for example through taster sessions.

In answer to a question from Mr McConnell on the strong links to Edinburgh University, Professor Thomson noted that this was historical, adding that every opportunity was taken to engage with other universities and further links were being developed with University of Glasgow. Given the geographical location of TSH, it was likely that there would continue to be a focus on the central belt. Ms Radage asked if there had been any notable changes in working patterns compared to pre-pandemic levels especially on flexibility on working hours. Professor Thomson confirmed that part–time working was increasing, and usually related to childcare pressures. This appeared to be a more general trend rather than solely contributable to the pandemic. This trend showed the need for greater flexibility of approach to ensure that TSH remained attractive to trainees.

Mr Moore summarised for the Board on the very positive nature of the report, and evidence of the quality of training provided at TSH as a centre of excellence.

The Board was content to note this update.

The Board:

1. Noted the content the report.

15 CLINICAL FORUM

The Board received a copy of the approved minutes of the meeting, which took place on 17 May 2022, as well as a verbal update from Dr Sheila Howitt, as the Chair, on the latest meeting, which took place on 20 September 2022. Key areas of discussion had been around the new clinical model, the Grounds Access Policy and the functioning of the professional advisory committee structure.

The Board:

1. Noted the approved minutes of the Clinical Forum meeting held on 17 May 2022.
2. Noted the update from the Clinical Forum Chair.

STAFF GOVERNANCE

16 WORKFORCE PLAN 2022 -2025

The Board received a report from the Director of Workforce (Paper No. 22/92) submitting the finalised TSH Workforce Plan 2022 - 2025 for approval, and including the feedback letter received from Scottish Government. Mrs McGovern highlighted the updates made to the plan, and confirmed that subject to Board approval the intention was for this to be published on the website, and for the supporting action plan to be progressed.

Mr McConnell asked if TSH had been asked by government to provide indicative costs for the development of a female service within TSH, and Mr Jenkins advised that work had been carried out to project the approximate revenue cost of this for TSH, and place in context of costs of present service arrangements. Ms McGovern confirmed that the workforce plan would be updated in line with any development in this area. Mr Moore noted the balanced nature of the gender mix in nursing, and Ms McCaffrey advised that this was being kept under review, especially given fewer males seeking careers in mental health nursing, and that opportunities were being explored to make TSH an attractive place to work.

On behalf of the Board, Mr Moore noted the helpful and detailed nature of the three-year workforce plan, and confirmed the Board's approval of it.

The Board:

1. Approved the TSH Workforce Plan 2022-2025

17 WORKFORCE REPORT

The Board received a report from the Director of Workforce (Paper No. 22/93) to provide an update on overall workforce performance to 30 September 2022, and Ms McGovern summarised the key metrics contained within the report for the Board. She highlighted the change in format and content of the report, to reflect the feedback from the Board at its last meeting, as well as the more detailed reporting submitted to the Staff Governance Committee.

Mr Currie commented on the increase in the long-term absence rate to 8%, and asked for clarification as to how this correlated to short term absences, and how staff were supported back to work proactively e.g. through redeployment or changes to their existing role. He emphasised the importance of this especially for absences related to stress, anxiety and depression. Ms McGovern noted the impact of the change in how long covid absence was recorded, as this was now within the overall sickness absence figures. Further, that there was a focus on identifying whether the stress experienced was related to workplace, so that focused support was provided. Mr Jenkins added that refresh of the occupational health package could help to focus support in a tailored way, and acknowledged that a redeployment strategy was required. It was noted that the Staff Governance Committee would take oversight of this package of measures.

Ms Fallon then commented positively on the inclusion of attendance management as part of the Senior Charge Nurse programme. Mr Moore noted the potential risk of significant winter pressures, and the related impact on overtime costs.

The Board:

1. Noted the content of the report

18 STAFF AND VOLUNTEER WELLBEING REPORT

The Board received a report from the Director of Workforce (Paper No. 22/94) which outlined the progress made in the last six months on implementing the strategy, and monitoring of the key performance indicators (KPIs). Ms McGovern outlined the key points for the Board, highlighting the way in which the strategy was supported through an action plan, and related KPIs.

In answer to a question from Mr McConnell on the availability of wellbeing resource to all staff including those on front-line roles, Ms McGovern noted that the Staff Care Specialist was leading outreach work. She would be attending the Staff Governance Committee in November to provide an update on progress.

Ms Fallon noted the availability of mental health awareness training, and asked how peer supporters were being facilitated. Ms McGovern advised that this was being rolled out in nursing during November 2022, and that an update would come back to the Board in this respect. Mr Moore added that it would also be beneficial for further assurance on how the volunteer cohort within the hospital were being supported through implementation of this strategy. Mr Jenkins noted the importance of taking a balanced multi-sourced approach across all aspect of staff and volunteer wellbeing, and recognised that detailed oversight of the evolution of this approach would be taken through the Staff Governance Committee.

Action(s) - Ms McGovern

The Board:

1. Noted the content of the report and the updates contained therein.

CORPORATE GOVERNANCE

19 ANNUAL OPERATING PLAN AND DELIVERY PLAN 2022/23

The Board received a report (Paper No. 22/95) from the Head of Planning and Performance submitting the TSH Annual Operating Plan (AOP) and Delivery Plan 2022/23, to the Board for its review and approval. The report also included the feedback received from Scottish Government on these plans, and Ms Merson summarised this for the Board's information. Feedback had been very positive and the AOP had been accepted by government. Ms Merson noted that quarter 1 reporting on the Delivery Plan was submitted in July, and that Quarter 2 would be submitted by the due date of 28 October. TSH and the Mental Health Directorate (MHD) now had formal quarterly sponsorship meeting in place with the next meeting taking place on 28 November 2022.

There was positive agreement from the Board that this provided a very good understanding of the aims of the Board in terms of patient care, as well as reflecting well on achievements made, especially within a climate of financial pressures. The positive feedback from the MHD was noted as giving confidence in this workstream, and the focus on deliverables during the current year.

Mr Moore summarised for the Board that this reporting provided strong evidence of what TSH was delivering on, and that the AOP and Delivery Plan for 2022/23 were approved.

The Board:

2. Noted the content of the report and the updates contained therein.

20 SUSTAINABILITY AND CLIMATE CHANGE REPORT

The Board received a report from the Director of Security, Resilience and Estates (Paper No. 22/96) detailing the work undertaken to date within TSH in support of the NHS Climate Emergency and Sustainability Strategy 2022-2026. Mr Walker presented the report to the Board providing a summary of the key areas of progress to date, as well the governance arrangements and development of a risk assessment as part of the Corporate Risk Register. He advised that a site energy survey had been carried out and that an update from this would be provided through the Board, suggesting as part of a development session. Further, that the template for annual reporting had only recently been received, and that this was now due for 1 January 2023.

Mr Moore summarised the discussion, noting that this would be a beneficial area for the Board to focus on in a development session, and also that Ms Fallon had direct Non Executive oversight and was linked in nationally.

Action - Mr Walker/ Ms Smith

The Board:

1. Noted the content of the report, and agreed to further updates around the development of an annual report as well as wider discussion within a development session. .

21 FINANCE REPORT TO 30 SEPTEMBER 2022

A paper was submitted to the Board (Paper No. 22/97) by the Finance and eHealth Director, which presented the financial position to 30 June 2022, reporting on revenue and capital resource spending plans as well as the projected yearend financial outturn.

Mr McNaught provided a summary of the report, and advised that a breakeven position was projected for year-end, and that there was currently a small underspend. He confirmed that budget savings plans were ongoing throughout all directorates, and that the capital budget was fully utilised. Additional funding applied for and received in relation to backlog maintenance had been allocated, and was projected to be fully utilised within the current year.

Mr Currie asked how the general increase in fuel process would affect budgeting, and noted the overall financial pressures all NHS Boards would experience in the coming year. Mr McNaught acknowledged

these pressures and confirmed that fuel costs were being monitored very closely. Mr Walker added that he could provide further detail for the Board on fuel use within TSH, including planned steps for future proofing this especially within the context of climate change. The Board noted that this would be helpful additional information and could form part of the proposed development session in this regard, as well as financial aspects to the Board.

Action – Mr Walker/Mr McNaught

Mr Jenkins added that the very high percentage rate of staff costs as part of revenue (at 84%) continued to be a significant pressure for TSH as compared to other Boards, leaving less opportunity for savings and service development.

In answer to a query from Mr McConnell on the possible impact of pay as if at work (PAIAW) Mr McNaught provided assurance that this risk was closely monitored and estimated on a precautionary basis and so was not of additional concern. He also confirmed that NHS Board responsibility to pay for an Agenda for Change pay increase in excess of 5% would be an additional pressure. It was discussed and agreed around the table that any significant change, which presented additional risk to the projected outturn, should be escalated to the Board.

Action – Mr McNaught

The Board was content to note this update report.

The Board:

1. Noted the content of the report.
2. Noted that additional and significant financial risk should be escalated to the Board.

22 PERIMETER SECURITY AND ENHANCED INTERNAL SECURITY SYSTEMS PROJECT

The Board received a report from the Director of Security, Resilience and Estates (Paper No. 22/97) detailing the update of the Perimeter Security and Enhanced Internal Security Systems re-fresh project and planning for the remainder of this year.

The Board noted this paper, and that the project was nearing conclusion. A further report would be presented in a private session of the Board, given the security and commercial sensitivities.

The Board:

1. Noted this update in relation to the perimeter Security and Enhanced Internal Security Systems Project and recognised that this was a feature within the Private Session of the Board Meeting.

23 COMMUNICATIONS:

(a) ANNUAL REPORT 2021/22

A paper was submitted to the Board (Paper No. 22/99) by the Head of Communications to provide annual reporting in respect of communications activity for 2022/23

Ms McCarron presented a summary overview for the Board, emphasising the key activities throughout the year, and the achievement of key performance indicators as outlined within the report. She also highlighted the development of social media engagement for TSH, and how this was developing with stakeholders. Further, development of two new posts within the service, to help develop it further.

Ms Fallon commented on the positive development of the patient internet, and asked if further background could be provided on carer events.

Action – Ms McCaffrey/ Ms McCarron

There was discussion around the table on the development of a social media presence for TSH, and the challenges this could bring alongside opportunities. Although some negative interactions may be inevitable, there was benefit it engagement and in transparency.

Mr Jenkins noted the positive direction of travel in communications, and the need to keep evolving the service. Mr Moore noted that the report demonstrated openness, and this could be seen in the way complaints were assessed in terms of being upheld or not. He also commented that it was reassuring that the SPSO had not taken forward any investigations during the year, or offered suggestions for further learning. He summed up for the Board, on being content with the report as presented.

The Board:

1. Noted the content of the report.

(b) SERVICE UPDATE

A paper was submitted to the Board (Paper No. 22/100) by the Head of Communications to provide an update on the continued development of the service, and Ms McCarron summarised the key points including increased capacity and the work progressed on web redesign. She provided a link so that the Board could view progress on the website.

Mr Moore summed up for the Board, on being content with the reports as presented, across a range of initiatives. The service development with increased capacity provided the opportunity for significant change and improvement in the coming year.

The Board:

1. Noted the content of the report.

24 INFORMATION GOVERNANCE ANNUAL REPORT 2021/22

The Board received a report from the Director of Finance and eHealth (Paper No. 22/101) to provide annual reporting to the Board for 2021/22. Mr McNaught introduced the report, underlining the increased focus in this area as well as the comprehensive nature of reporting. Mr Lawton joined the meeting to present an overview to the Board. He outlined the focus on the substantial change in Information Governance Standards, and the development of the Data Protection Compliance Toolkit based on the Information Commissioner Officer's (ICO) accountability framework. Further, the upcoming audit to be undertaken by ICO of all NHS Boards in Scotland. TSH were expected to undergo this during November. He added updates on the work continuing to deliver information governance training, as well as to review any potential personal data breaches and deliver responses to Freedom of Information Requests.

There was agreement from the Board on the positive nature of reporting and comprehensive reporting, and thanks to Mr Lawton for his work.

The Board:

1. Noted the content of the report.

25 EHEALTH REPORTING:

(a) ANNUAL REPORT 2021/22
(b) DIGITAL INCLUSION REPORT

The Board received two papers from the Director of Finance and EHealth providing reporting on

eHealth activity: an Annual Report 2021/22 (Paper No. 22/102) as well as a Digital Inclusion Update (Paper No. 22/103).

Mr McNaught provided an overview of each report. He highlighted the range of activities undertaken by EHealth, and the commitment by the team to deliver key projects during the year. In particular, the upgrade to the electronic patient records system (RiO) had been successful, with a very high level of engagement required across the organisation as well as dedicated training. Additional functionality could be added, and consultations were progressing with clinical colleagues as to how best to develop adaptations to the system. He also asked the Board to note the Network and Information Systems (NIS) Audit had been carried out, with feedback on this awaited. Mr McNaught confirmed that he would bring an update to the Board in this respect, when available.

Action - Mr McNaught

Mr McNaught also summarised the work progressed in respect of the digital inclusion agenda, including patient screens, the functionality of which had grown in scope since originally planned, and the benefit this would give for patients.

Mr Currie welcomed the positive nature of progress, noting how technology could support equality of access, empowering both patients and carers. The development of digital visiting was a great benefit especially given the hospital's location. It was good to see development being made consistently over time. Ms Radage echoed this sentiment, and that it was pleasing to see the development of the patient screens with added functionality. She added that it would be important not to over promise on delivery timescale, to avoid disappointment, as it was clear this would be a significant change for patients. Mr McNaught concurred and provided assurance that there would require to be continued engagement work due to the complexity and security aspects, so this would bring an opportunity to ensure that patients were kept well informed on progress.

Mr Moore asked whether the enhancements to RiO had to date served to free up or consume time for staff. Professor Thomson advised that there was increased investment of time, in terms of data entry, however, the live dashboard system would be a highly useful tool to facilitate swift circulation of reporting which would support clinical decision-making, decreasing work burdens.

Mr Moore summed up for the Board, and thanked the eHealth team for the tremendous progress made, which had been transformative over a short period of time.

The Board:

1. Noted the content of the report.

26 BOARD AND COMMITTEE SCHEDULE 2023

The Board received a report from the Board Secretary (Paper No. 22/102) to confirm the schedule of meeting for 2023. Ms Smith confirmed the meeting would be as set out save for one required change to the Audit Committee, and that a final set of meeting dates would then be circulated and arranged.

The Board:

1. Noted the content of the report.

27 ANY OTHER BUSINESS

There were no additional items of competent business for consideration at this meeting.

28 DATE AND TIME OF NEXT MEETING

The next public meeting would take place on 22 December 2022, by way of MS Teams.

29 PROPOSAL TO MOVE TO PRIVATE SESSION

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

The meeting ended at 1.35pm.

ADOPTED BY THE BOARD

CHAIR

DATE

NHS SCOTLAND

THE STATE HOSPITALS BOARD FOR SCOTLAND
ROLLING ACTION LIST

ACTION NO	MEETING DATE	ITEM	ACTION POINT	LEAD	TIMESCALE	STATUS
1	February 2021/April 2021	Resilience Report – Covid-19 (Item 7a)	Provide benchmarking comparison to other organisations on use of virtual visiting	R McNaught	Adjusted to June 22	Updated October 2022: On Agenda, and now on board workplan for regular updates. Closed
2	December 2021	Patient, Carer Volunteer Story (Item 8)	Request that stories return to being presented first hand, using digital means if possible, as soon as service delivery allows.	K McCaffrey	Adjusted to August 2022	Updated October 2022: Added to Board workplan to specify more direct contributions from patients and carers. Closed
3	February 2022	Resilience Report – Covid-19 (Item 7a)	Updating on Family Centre infrastructure/ capital plan and progress of SLWG	D Walker	Adjusted to June 2022	Updated October 2022: Added to Board Workplan for regular reporting Closed
4	February 2022	Corporate Risk Reg (Item 8)	Update on directorate review of risks with Risk team – ensure added as topic to Board Seminar programme for 2022 - to agree timing/ content.	D Walker/ M Smith	August 2022	Updated October 2022: sessions arranged Closed
5	April 2022	QA and QI (Item 11)	Update on Carer's clinic workstream	K McCaffrey	December 2022	Update June 2022: Progress with clinic in 2 Hubs during Feb – May 2022. Given

						positive feedback, further clinics will be held on 3-monthly basis. Feedback Reporting to be prepared end of November, and then update back to the Board planned for December meeting. **Update December:** This is part of Realistic Medicine Update – Completion of four clinics at a minimum required before detailed assessment could be undertaken, timing of final clinical was at end of November and work is underway and not yet complete. **This should return to the Board as part of QA/QI report at February 2023 meeting.**
6	August 2022	Corporate Risk Register	Review for next report: FD96 – Cyber Security HRD111- Information leaks	R McNaught/ D Walker L McGovern/ D Walker	October 2022	Updated October 2022: Risks reviewed and presented as part of CRR report. Closed.
7	August 2022	Resilience Update – Governance	Operational Response Plan to be brought to next meeting	K McCaffrey	October 2022	Updated October 2022: Report on agenda. Closed.
8	August 2022	Workforce report	Development of reporting to differentiate requirements for SGC and Board: Board to received summary and link only.	L McGovern	October 2022	Updated October 2022: Report on agenda, updated and tableau reporting circulated as background information in support.

			Updates to: -Reporting time frames – so not mix of periods to avoid confusion -Provide link of overtime costs to staff attendance and show change over time -review to ensure no risk of jigsaw ID given low reporting numbers			Closed
9	October 2022	Operational Response Plan	Update on trigger points of escalation and link to the Board.	K McCaffrey	December	**Update December:** On Agenda – Item 8
10	October 2022	QA/QI Report	Re AOG section: update on terminology used	K McCaffrey	December	**Update December:** Confirmed that terminology around patient activity within hubs was updated, and assurance to Board. **CLOSE**
11	October 2022	Wellbeing Reporting	Re: performance KPIs – footfall in Wellbeing Centre Re: Peer Support progress Re: Volunteers link to wellbeing workstream and centre	L McGovern	December	**Update December:** Footfall into centre continues to be monitored e.g. October Footfall – 265 visits Peer Support – First training course commences on Friday 16 December Volunteer input – communications are sent to volunteers on a regular basis and they utilise the facilities within the Wellbeing Centre

						when on-site Wellbeing Report will be submitted to Staff Governance Committee in February, and update to the Board in April 2023. **CLOSE**
12	October 2022	Sustainability	Add sustainability and climate change to future board development session	D Walker/ M Smith	December	Development Sessions dates for 2023 planned and item added. **CLOSE**
13	October 2022	Finance	Fuel update / Escalate re financial sustainability to Board development session	D Walker R McNaught	December	Development Sessions dates for 2023 planned and item added. **CLOSE**
14	October 2022	Communications Report	Update on carer social events in current year	K McCaffrey	December	**Update December:** This is under active review, with consideration of a different approach post Covid and implementation of new clinical model, with the change to the Family Centre as central visiting space, as well as feedback from carers that they would like smaller more tailored events. Therefore, review will take place in spring 2023 on refreshed way forward. **Board to consider if wish further dedicated update.**

15	October 2022	Ehealth	Feedback to Board after NIS Audit	R McNaught	December	**Update December:** NIS audit report expected to be available for February 2023 meeting

Last updated – 16.12.22 – M Smith

Author:
Margaret Smith
Board Secretary 01555 842012

Paper No: 22/110

THE STATE HOSPITALS BOARD FOR SCOTLAND

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

1 SITUATION

A corporate risk is a potential or actual event that:

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

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

2 BACKGROUND

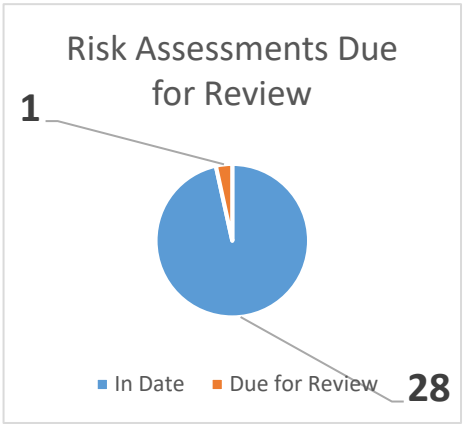
Each corporate risk has a nominated executive director who is accountable for that risk, as well as a nominated manager who is responsible for ensuring adequate control measures are implemented.

3 ASSESSMENT

3.1 Current Corporate Risk Register - See appendix 1.

3.2 Out of Date Risks

SD54 - Implementing Sustainable Development in Response to the Global Climate Emergency is due for review. Meeting scheduled for 21st December to discuss results of Carbon Report which will inform grading, review delayed to accommodate this.



3.3 Update on Proposed Risks for inclusion on Corporate Risk Register

- Corporate Risk **CE15 – Impact of Covid-19 Inquiry** was approved at CMT and has been added to the Corporate Risk Register. The full risk assessment is available in **Appendix 2**. The risk is currently graded 'High' and will be reviewed monthly in line with TSH policy.

3.4 Corporate Risk Register Updates

3.4.1 HRD111 – Deliberate Leaks of Information

In light of the recent media enquiries to The State Hospital suggesting a leak of information to the press, the grading for HRD111 has increased from 'Medium' to 'High'. The likelihood of this risk being realised has increased from 'Unlikely' to 'Possible' giving an overall 'High' grading. 4 media enquiries were received between 16th August 22 and 6th November 22 pertaining to an ongoing investigation within the hospital. The Risk and Resilience Team are currently investigating the events surrounding the incident. The team will liaise with the HR Director to develop measures to mitigate this risk. This is risk will be reviewed monthly.

3.4.2 HRD112 – Compliance with PMVA Refresher Training

The grading for HRD112 has reduced from a 'Medium' risk to a 'Low' risk. The likelihood has reduced from 'Moderate' to 'Rare. The reduction in likelihood was changed as the compliance level for staff training is at 92% which is above the target level. Additional sessions have been scheduled to maintain this figure in 2023. This risk will be reviewed every 6 months.

3.5 High and Very High Risk – Monthly Update

The State Hospital currently has **Six** 'High' graded risks, up from **Four** in the last report, latest updates are below:

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

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

Monthly Update: Level 3 PPE training has been completed, Bronze Commander Training has also been completed. Awaiting paper regarding implementation of Level 3 PPE to be approved at CMT with an aim to go live in January 2023. Updates will be provided relating to progress. Once live, incidents will continue to be monitored and analysed by the Risk and Resilience Team with the risk assessment updated as required.

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

Monthly Update: Latest Obesity figures reduced slightly to 82.7% from 83.1% in November 2022. It was noted however that 5.5% of data was missing which may alter final figures.

Plan to start a Health Education Group to run in 2023 to continue to support making healthier choices and adopting healthier lifestyles. Action Plan is being reviewed to condense some of the outstanding actions under Supporting Healthy Choices and Health Psychology work streams.

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

Monthly Update: Staffing issues continue to affect TSH. Daily meeting takes place to monitor staff resources in real time managed through the 'Safe to Start' Process.

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

Staffing is being monitored daily and continues to be a priority for the Hospital, recruitment is ongoing and modified working/closures being utilised where required. On-Call being utilised on the weekends and during difficult periods to provide support to nursing staff if escorts are required.

- **SD54 Implementing Sustainable Development in Response to the Global Climate Emergency**

Monthly Update: Risk is currently at High but is due for review. Carbon Report is now available and meeting scheduled for 21st December 2022 to discuss and review findings. Risk Assessment will be updated once position at TSH is clear.

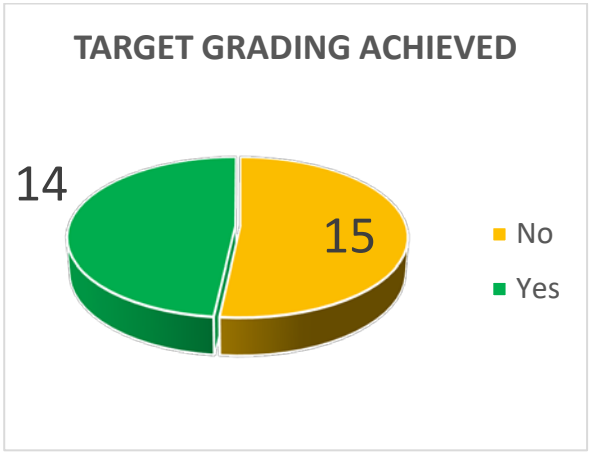
- **HRD111 – Deliberation Leaks of Information (Increased to High in November 2022)**

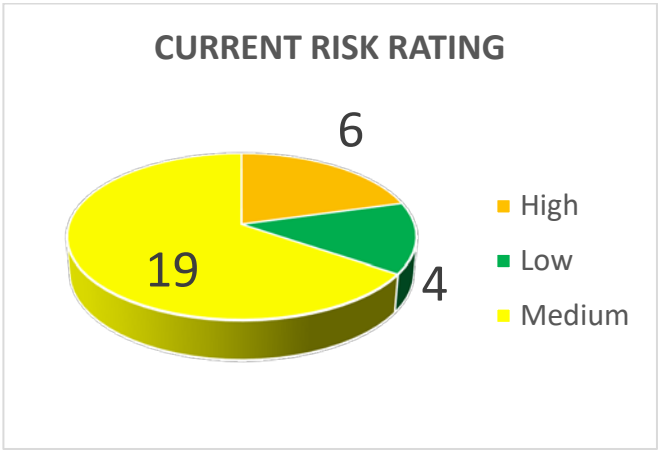
Monthly Update: Risk grading increased to High after multiple media enquiries were received at TSH suggesting potential leaks of information. The Risk and Resilience Team are currently investigating the events surround the incident and will work with the Director of HR to put together an action plan to mitigate against any future leaks.

- **CE15 - Impact of UK and TSH Covid-19 Inquiries on TSH (New for December 2022)**

Monthly Update: Risk Assessment was approved at CMT in December 2022. Risk has been graded as High initially and will be reviewed monthly. The TSH Covid Enquiry Short Life Working Group will monitor this risk and share feedback with CMT and the Board as the enquiry progresses. Full details of the risk assessment are available in **Appendix 2.**

3.6 Risk Distribution





Currently 14 Corporate Risks have achieved their target grading, with 15 currently not at target level.

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

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

	Negligible	Minor	Moderate	Major	Extreme
Almost Certain					
Likely			ND70,	MD30, SD54	
Possible			CE12, SD57, FD91, ND73, FD98, CE14	ND71, HRD111	
Unlikely			MD33, SD55, FD90, HRD110,	MD34, SD51, SD50	CE15
Rare			FD97, CE13, SD52, HRD112	MD32, FD96, SD56,	CE10, CE11, SD53

Review Periods:

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

4 RECOMMENDATION

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

Paper No: 22/110
MONITORING FORM

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

Paper No: 22/110

High Risks

Ref No.	Category	Risk	Initial Risk Grading	Current Risk Grading	Target Risk Grading	Owner	Action officer	Next Scheduled Review	Governance Committee/ Management Group	Monitoring Frequency	Movement Since Last Report
Corporate MD 30	Medical	Failure to prevent/mitigate obesity	Major x Likely	Major x Likely	Moderate x Unlikely	Medical Director	Lead Dietitian	01/11/22	Clinical Governance Committee	Monthly	-
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 & Ops	Director of Nursing & AHP	01/11/22	Clinical Governance Committee	Monthly	-
Corporate ND 71	Health & Safety	Failure to assess and manage the risk of aggression and violence effectively	Major x Possible	Major x Possible	Major x Possible	Director of Nursing & Ops	Director of Nursing & AHP	01/11/22	Clinical Governance Committee	Monthly	-
Corporate SD 54	Service/Business Disruption	Implementing Sustainable Development in Response to the Global Climate Emergency	Major x Likely	Major x Likely	Moderate x Rare	Security Director	Head of Estates and Facilities	01/12/22	Security, Risk and Resilience Oversight Group	Monthly	-
Corporate CE15	Reputation	Impact of Covid-19 Inquiry	Extreme x Likely	Extreme x Possible	Extreme x Rare	Chief Executive	Board Secretary	01/01/23	CMT/Board	Monthly	-
Corporate HRD 111	Reputation	Deliberate leaks of information	Major x Possible	Major x Possible	Moderate x Unlikely	Director of Workforce	HR Director	01/01/23	Staff Governance Committee	Monthly	Likelihood ↑

Medium Risks

Ref No.	Category	Risk	Initial Risk Grading	Current Risk Grading	Target Risk Grading	Owner	Action officer	Next Scheduled Review	Governance Committee	Monitoring Frequency	Movement Since Last Report
Corporate CE 10	Reputation	Severe breakdown in appropriate corporate governance	Extreme x Possible	Extreme x Rare	Extreme x Rare	Chief Executive	Board Secretary	01/01/23	Corporate Governance Group/Board	Quarterly	-
Corporate CE 11	Health & Safety	Risk of patient injury occurring which is categorised as either extreme injury or death	Extreme x Possible	Extreme x Rare	Extreme x Rare	Chief Executive	Chief Executive	01/01/23	Clinical Governance Committee	Quarterly	-

Corporate CE 12	Strategic	Failure to utilise appropriate systems to learn from prior events internally and externally	Major x Possible	Moderate x Possible	Moderate x Unlikely	Chief Executive	Risk Management Team Leader	01/01/23	Security, Risk and Resilience Oversight Group	Quarterly	-
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	Moderate x Possible	Minor x Possible	Chief Executive	Chief Executive	01/01/23	CMT/Board	Quarterly	-
Corporate MD 32	Medical	Absconsion of Patients	Major x Unlikely	Major x Rare	Moderate x Rare	Medical Director	Associate Medical Director	01/01/23	Clinical Governance Committee	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	01/01/23	Clinical Governance Committee	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	01/01/23	Clinical Governance Committee	Quarterly	-
Corporate SD 50	Service/Business Disruption	Serious Security Incident	Moderate x Possible	Major x Rare	Major x Rare	Security Director	Security Director	01/01/23	Security, Risk and Resilience Oversight Group	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	01/01/23	Security, Risk and Resilience Oversight Group	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	01/01/23	Security, Risk and Resilience Oversight Group	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	01/01/23	Security, Risk and Resilience Oversight Group	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	Security Director	Head of Risk & Resilience	01/01/23	Security, Risk and Resilience Oversight Group	Quarterly	-
Corporate ND 73	Service/Business Disruption	Lack of SRK trained staff	Moderate x Likely	Moderate x Possible	Moderate x Unlikely	Director of Nursing & Ops	Director of Nursing & Ops	01/01/23	Clinical Governance Committee	Quarterly	-

Corporate FD 90	Financial	Failure to implement a sustainable long term model	Moderate x Unlikely	Moderate x Unlikely	Moderate x Rare	Finance and eHealth Director	Finance & Performance Director	01/01/23	Finance, eHealth and Performance Group	Quarterly	-
Corporate FD 91	Service/Business Disruption	IT system failure	Moderate x Possible	Moderate x Possible	Moderate x Possible	Finance and eHealth Director	Head of eHealth	01/03/23	Finance, eHealth and Performance Group	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 eHealth Director	Head of eHealth	01/03/23	Finance, eHealth and Performance Group	Quarterly	-
Corporate FD 98	Reputation	Failure to comply with Data Protection Arrangements	Moderate x Unlikely	Moderate x Unlikely	Moderate x Rare	Finance and eHealth Director	Head of eHealth/ Info Gov Officer	01/03/23	Finance, eHealth and Performance Group	Quarterly	-
Corporate HRD 110	Resource	Failure to implement and continue to develop the workforce plan	Moderate x Possible	Moderate x Unlikely	Minor x Rare	HR Director	Director of Workforce	01/01/23	HR & Wellbeing/Staff Governance Committee	Quarterly	-

Low Risks

Ref No.	Category	Risk	Initial Risk Grading	Current Risk Grading	Target Risk Grading	Owner	Action officer	Next Scheduled Review	Governance Committee	Monitoring Frequency	Movement Since Last Report
Corporate CE 13	Strategic	Inadequate compliance with Chief Executive Letters and other statutory requirements	Moderate x Unlikely	Moderate x Rare	Moderate x Rare	Chief Executive	Board Secretary	01/04/23	CMT/Board	6 monthly	-
Corporate SD 56	Service/Business Disruption	Water Management	Moderate x Unlikely	Moderate x Rare	Moderate x Rare	Security Director	Head of Estates and Facilities	01/05/23	Security, Risk and Resilience Oversight Group	6 monthly	-
Corporate FD 97	Reputation	Unmanaged smart telephones' access to The State Hospital information and systems.	Major x Likely	Moderate x Rare	Moderate x Rare	Finance and eHealth Director	Head of eHealth	01/04/23	Finance, eHealth and Performance Group	6 Monthly	-
Corporate HRD 112	Health & Safety	Compliance with Mandatory PMVA Level 2 Training	Major x Unlikely	Moderate x Rare	Moderate x Rare	Director of Workforce	Training &Development Manager	01/01/23	Clinical/Staff Governance Committees	6 Monthly	Likelihood ↓

Appendix 2

Impact of UK and TSH Covid-19 Inquiries on TSH

Ref: CE15

Corporate Objective	Better Care	Risk Owner	Chief Executive	Action Officer	Board Secretary

Risk	Complete the relevant details of the operation/ activity giving risk to the risk
The risk that TSH fails to meet its statutory obligation to meet calls for evidence from the UK and Scottish Covid-19 Inquiries. Public Inquiries cannot determine criminal or civil liability, but liability may be inferred and flow from the facts as established by an Inquiry. It is a criminal offence to intentionally withhold evidence or to obstruct the work of a Public Inquiry.	

Category		Tick the box to indicate the type of risk
Staffing	☒	
Financial & Organisational	☒	
Clinical	☐	
Physical	☐	
Project	☐	
Other (Specify)	☐	

Hazards		Details the hazards associated with this risk, i.e. the effect. Impact of this risk if realised
- Pressure on resources due increased workload for the duration of two simultaneous Inquiries; with legal requirement to respond to any requests for information within timetable set by each Inquiry. - Projects and planned activities potentially delayed to accommodate the increased workload in certain departments. - Legal power to compel witnesses to give oral evidence – TSH staff potentially required to give evidence. Those involved in responding to may suffer from increased stress and anxiety due to the statutory nature of this in public hearings. - Financial pressure of increased legal costs in the legal representation required. - Reputational and financial impact to the organisation if evidence submissions do not meet standards set by the inquiries, with both criminal and financial sanctions being available to each Inquiry.		
Individuals or group exposed	Staff	Highlight those who would be affected by risk

Benefits	Detail any benefits associated with this risk being mitigated. (e.g. cost savings)
Meeting legal duty to fully cooperate with the two Inquiries, demonstrating TSH willingness to be open and transparent and to assist the investigating bodies in learning lessons for the future. Further benefit in taking lessons learned from review of practice throughout the organisation, through preparation of evidence submissions. Managing the workload correctly will allow TSH to operate as normal during the duration of the two inquiries.	

Existing Control Measures	List any existing measures in place to mitigate this risk.
- Central Legal Office instructed to provide expert advice and instruct counsel to represent TSH, decision for TSH to join territorial and special Board cohort as cohesive framework for managing response. - Legal costs met on pro-rata basis in line with existing arrangements under CNORIS. - TSH Covid Inquiries SLWG established and meeting monthly, chaired by Board Secretary and including Records Manager and Senior Analyst (eHealth). - Progress reporting required as standing items to CMT monthly and to Board bi-monthly. - Agreement for recruitment of Business Manager role to corporate Service, 12-month internal secondment.	

Likelihood	**Impact/Consequence**				
	Negligible	**Minor**	**Moderate**	**Major**	**Extreme**
Almost Certain	Medium	High	High	V High	V High
Likely	Medium	Medium	High	High	V High
Possible	Low	Medium	Medium	High	High
Unlikely	Low	Medium	Medium	Medium	High
Rare	Low	Low	Low	Medium	Medium

Risk Rating Refer to the QIS Matrix and descriptors (appendix 1) to assess the likelihood of the risk occurring and the impact it would have and determine the overall level of the risk.	**Impact/Consequence** (use descriptor relevant to proposal and select level of impact)	**Likelihood** (use descriptor relevant to proposal and select level of impact)	**Rating** R=I/C x L
Initial Risk Rating Risk grading without controls	**Extreme (5)**	**Likely (4)**	**Very High**
Target Movement Movement since last review	-	-	-
Target Risk Rating	**Extreme (5)**	**Unlikely (2)**	**High**
Current Risk Rating	**Extreme (5)**	**Possible (3)**	**High**

Further Control Measures Required	Include any additional controls identified to eliminate or reduce the risk further.
- Development of SLWG working to group to increase understanding across whole organisation on scope and powers of the two inquiries. - Monitoring and review of the resources required to answer the Inquiries, some departments may need extra support as a result. - Continue to report progress, and any potential risks, through CMT and to the Board. - Development of business systems within Corporate Service Team to support internal investigation, document management systems and management of submissions to two inquiries - Seek further expertise to support any staff asked to provide oral evidence directly to public hearing.	

Assurances	What assurances are there that current controls are effective? (Internal and external)
- Oversight taken directly by Board including regular update reporting and need to identify future risks - CMT oversight taken regularly at each monthly meeting meaning Executive Leadership have oversight, and can take action to mitigate any issues identified - CLO representation to provide expert advice, with KC retained as counsel. - Joined cohort of territorial and special Boards for legal representation, and reduction in costs; with proviso that any arising conflict of interest between Boards will be identified and separate representation effected for TSH if appropriate.	

Key Performance Indicators	Detail any existing KPIs that would link to risk and show performance against risk
Dictated by legal process. Key milestones in place to set up SLWG has been met, as well as governance mechanisms agreed by CMT and by Board for oversight.	

Date Added	13/10/2022
Completed by	Margaret Smith/Gary Jenkins/Stewart Dick
Date Reviewed	08/12/22
Next Review	12/01/23

Risk Register	Corporate Risk Register
Directorate	Corporate
Group/Committee Monitoring Risk	Corporate Management Team

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 December 2022
Agenda Reference:	Item No: 8
Sponsoring Director:	Director of Nursing and Operations & Director of Security, Resilience and Estates
Author(s):	Director of Nursing and Operations
Title of Report:	Operational Response Plan - Update
Purpose of Report:	Noting

1 SITUATION

There was agreement to review the Loss of Staff Plan (LOSP) at the October Board meeting. The purpose of the report is to provide an update regarding progress on this as well as related work regarding the DATIX reporting of staffing issues and the oversight and monitoring of modified working.

2 BACKGROUND

As previously advised, the introduction of Safe to Start has provided the State Hospital (TSH) with the ability to closely monitor staffing and respond timeously to any identified pressures.

As part of the suite of business continuity plans a loss of staff plan was developed for instances such as extreme weather where limited numbers of staff are able to attend site. In the early stages of the Covid pandemic, an extreme loss of staff plan was developed; and outlined plans at points of criticality for safe delivery of service provision. These were both introduced and developed early in the pandemic, however, the organisation has learned from the experiences of the past two years and regular testing of contingency plans.

This means as an organisation we are clearer regarding what can be safely managed and what would now constitute standing up an incident command structure.

There have been instances recently where despite the loss of staff it was felt that modified working measure could be put in place, which ensured the delivery of safe care. Therefore, the trigger for the loss of staff plan, including percentage of staff lost, requires review and revision.

3 ASSESSMENT

Datix is the system that is used to record loss of staffing events.

The Patient Safety Group received a report from the Head of Risk and Resilience, regarding an initial scoping of the DATIX reporting. From review, there, continues to be anomalies and duplication in the way in which the data is being entered for reporting.

There continues to be numerous individual reports submitted from staff relating to the same 'incident' of resource challenges. Furthermore, many of those incidents were pre-planned modified working models, agreed at the resource meetings, with senior decision makers being part of this process.

There is a clear definition given to modified working within TSH and the escalation process for authorisation of this.

Full Ward Closure– Ward is completely closed, with all patients having to be nursed in their room for the duration of an identified shift and this would be classed as Level 2 Seclusion and recorded for that time period. This excludes patients who clinical teams identify cannot tolerate extended time in their rooms and these individuals would be cared for in the main day area.

Partial Ward Closure – Ward is closed (as identified in Full Ward Closure) for a specified time frame during an identified shift e.g. from 0700-0900 or after 1700, with all patients being nursed in their room for that time period and this would be classed as Level 2 Seclusion and recorded for that time period. This excludes patients who clinical teams identify cannot tolerate extended time in their rooms and these individuals would be cared for in the main day area.

Modified Working – Local modified clinical operational changes in practice e.g. reduced number of patients within day area at one time.

The DATIX report highlighted variation across the hubs regarding application of modified working; there is a need to improve the consistency of this.

There were also many examples of good practice were staff had greatly reduced the impact of modified working within their wards. These examples of good practice need to be shared with the rest of the frontline staff.

There is further work required to improve the accuracy and reporting of the data and provide the site wide picture. It was agreed that the Patient Safety group would commission a small Task and Finish group to look at the LOSP, the use of Datix for accurate reporting aligned to the LOSP, and identify a consistent method of reporting on to Datix modified working and ward closure events.

The test of change aims to reduce reporting to once a day for the whole site. This will give timely and accurate information which can then be used to report the level of modified working, and closures, in a consistent way to assure the Board.

Next steps

The Patient Safety Group is overseeing this work and has commissioned a small task and finish group to review the following:

- The Loss of Staff plan.
- The use of DATIX reporting staffing resource issues, ensure there is a distinction between planned response and unplanned incidents and improve the accuracy of data which also clearly highlights when the trigger point for the Loss of Staff Plan has been reached.
- Reduce use of modified working and when used improve consistency of application.

The Task and Finish Group will report into the Patient Safety Group, chaired by the Director of Nursing and Operations with updated assurance reporting being routed to the

4 RECOMMENDATION

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

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Assurance reporting to the Board on operational service delivery
Workforce Implications	As outlined in the paper relating to the review of the Loss of Staff Plan
Financial Implications	No specific impacts identified as a result of this paper
Route to Board Which groups were involved in contributing to the paper and recommendations.	Board requested as action update as part of assurance framework
Risk Assessment (Outline any significant risks and associated mitigation)	Outlined as risk assessed approach in paper
Assessment of Impact on Stakeholder Experience	Patient impacts outlined within paper in relation to care delivery
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 √ There are no privacy implications. □ There are privacy implications, but full DPIA not needed □ There are privacy implications, full DPIA included

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 December 2022
Agenda Reference:	Item No: 9
Sponsoring Director:	Director of Nursing andOperations
Author(s):	Senior Nurse for Infection Control
Title of Report:	Infection Prevention & Control Report
Purpose of Report:	For Noting

1. BACKGROUND

This report is presented to the Board to provide an update in relation to Infection Prevention and Control (IPC) activity.

2. INFECTION PREVENTION & CONTROL ACTIVITY

During this review period the primary focus for the Infection Control Team (ICT) has been audit assurance and monitoring; developing terms of reference for the Infection Prevention and Control Group and reviewing the terms of reference for the existing Infection Control Committee

Hand Hygiene

The importance of appropriate and effective hand hygiene continues to be a priority for the ICT. This is continually monitored via the monthly Infection Control Audits. In addition to hand hygiene, compliance with wider aspects of infection control are also monitored.

Compliance with Hand Hygiene 6 Key Movements
Hand Hygiene audits are completed by a member of staff within the clinical area. 16 clinical areas are monitored and the completed audits are sent to the Clinical QI Facilitator by the 20th of each month. The ICT have increased the number of key moments from five to six. This is a deviation from the 'WHO 5 Key moments' however, it take cognisance of the hand hygiene opportunity when removing fluid resistant surgical masks.

Chart 1 shows the percentage of overall completion rate and shows an increase in compliance and is currently at 94%, just under the local target of 95% and a 3% increase from September 2022. As the figure is just under the target, it remains in amber in the RAG.

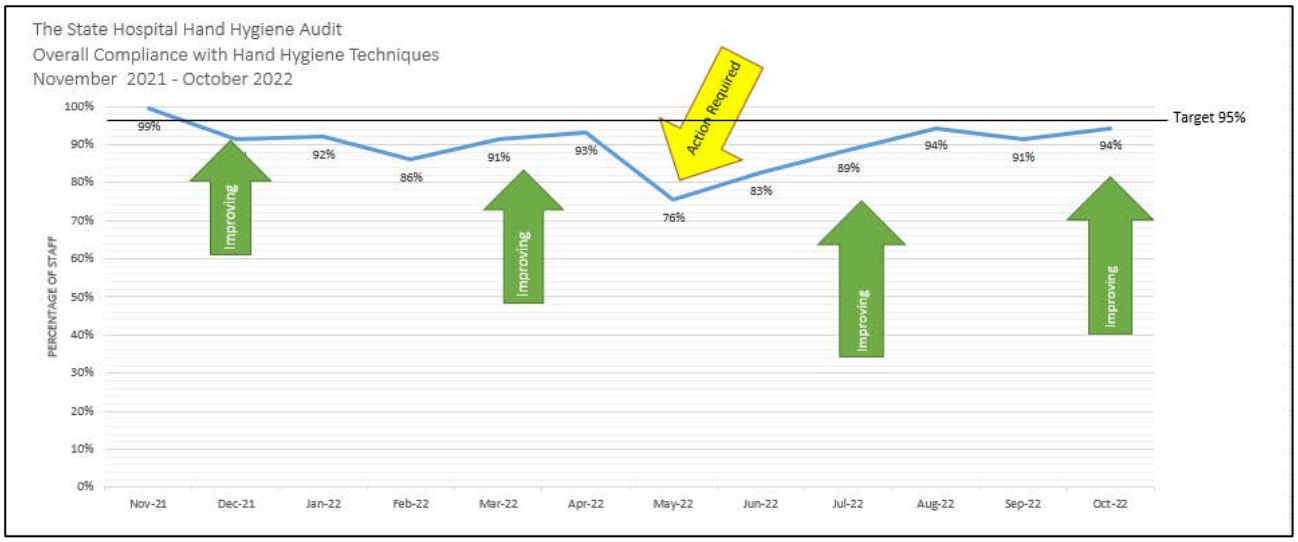
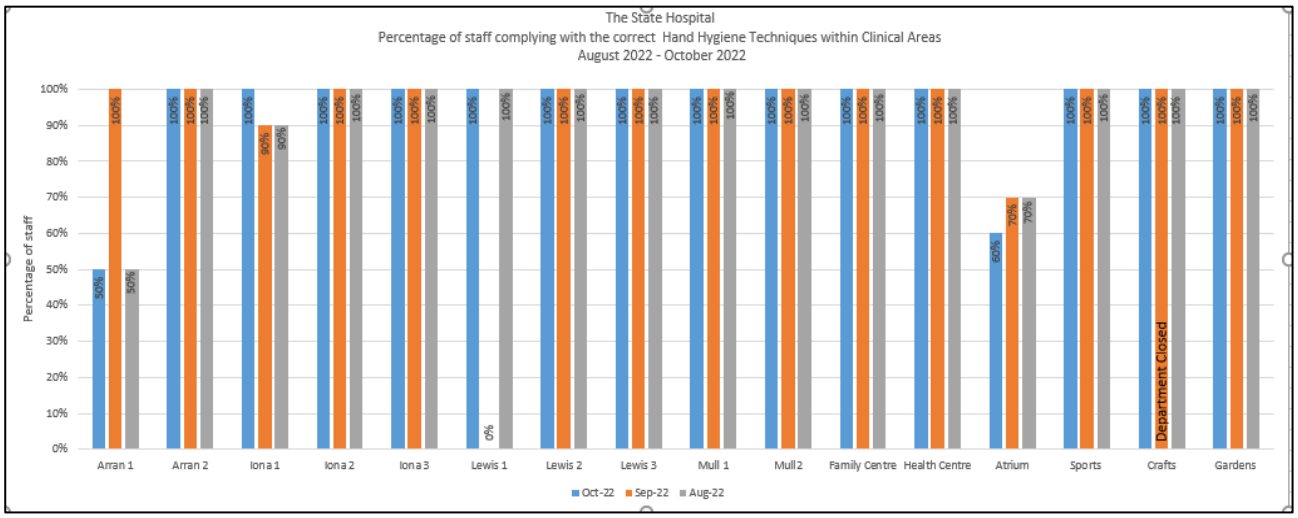


Chart 2, shows the breakdown (per clinical area) of compliance with hand hygiene technique over the last three months. As noted at Chart 1, all 16 clinical areas returned their audit tool for the month of October 2022. There has been a decrease in compliance in Arran 1 and Skye Centre Atrium; this has been documented in the monthly Senior Charge Nurse Report and included in the action plan. These action plans were prior to the ICC on 8th December 2022 and will include measures taken to improve compliance with Hand Hygiene techniques.

Chart 2



Following a review of the data provided by each clinical area, the total number of occasions where disciplines did not comply with Hand Hygiene Techniques whilst in a clinical area were 9:

- Code F: Housekeeping, Estates, Procurement and Porters x 5
- Code O: Admin staff, Senior management, Pharmacy, Social Work, Advocacy, Person Centre Improvement Team x 3
- Code N: Nurses / Skye Centre (Trained and Untrained) x 1

Action plans have been requested from the Senior Charge Nurses detailing measure to improve compliance. This will be reviewed by the Infection Prevention and Control Group.

Infection Control Audits

Infection Control audits are completed by a member of staff within the clinical area. 16 clinical areas require to be observed.

Chart 3, shows the overall average of staff complying with IPC measures to reduce the spread of infection. 16 areas submitted the audit for October, which is an improvement, following non-submissions being reported through July, August and September 2022. The overall average has significantly improved as the current percentage is 96%, over the local target set of 95% and is a 12% increase since September 2022. The RAG rate has changed from Red to Green.

Chart 3

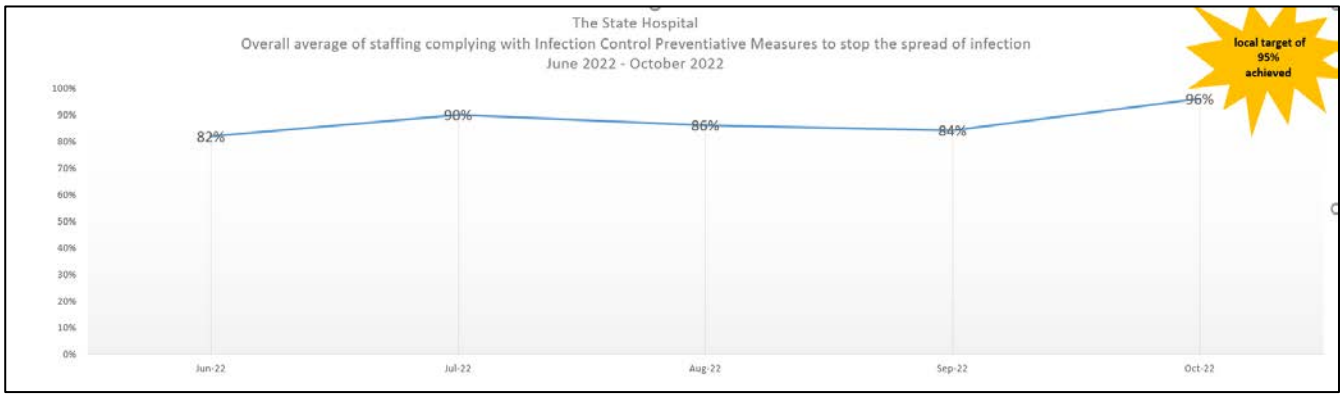
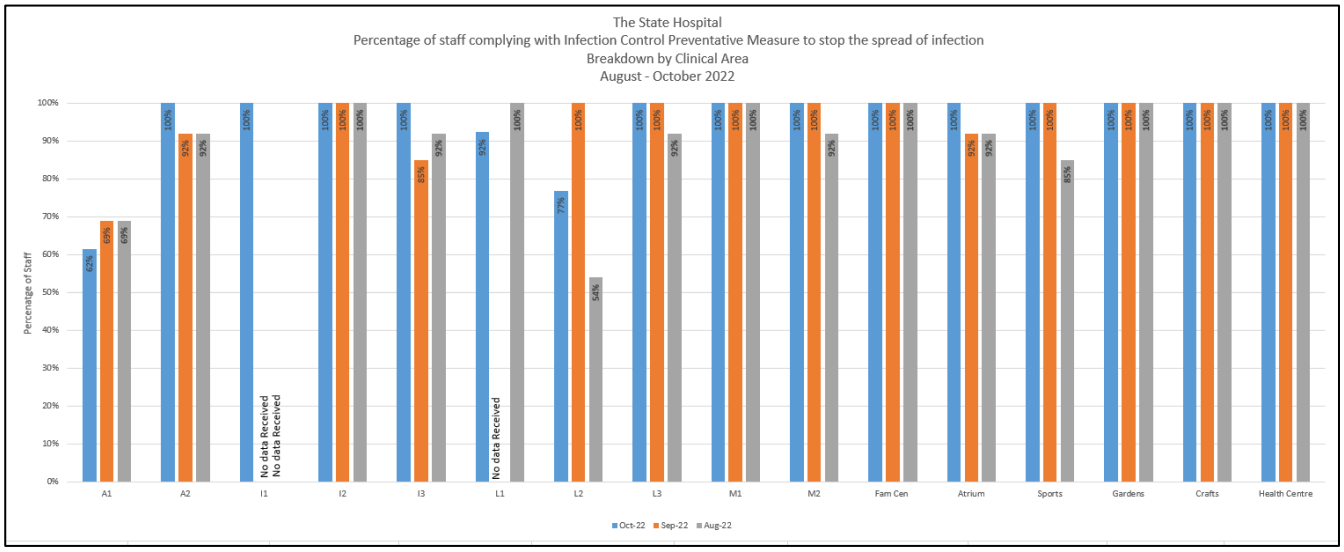


Chart 4, shows the breakdown by clinical area on compliance with control measures to stop the spread of infection. Although there has been an overall improvement, this is primarily as of the result of the audit tool returns. Over the last three months Arran 1 has never achieved over 70%. Lewis 2 has decreased from 100% to below 80%. The Skye Atrium has increased over the last month from 92% to 100%. Action plans have been requested from the non-compliant.

Chart 4



The reasons for non-compliance from October 2022 remain the same as September 2022 and are:

- Face masks being disposed of in the general waste bin
- Nursing staff wearing nail varnish
- Staff wearing False eye lashes
- Staff hair not tied back

Action plans have been requested from the Senior Charge Nurses detailing measure to improve compliance. This will be reviewed by the Infection Prevention and Control Group.

Face Fit Testing

Following data presented at the July 2022 Infection Control Committee an agreed target of 85% to be set to ensure that there was adequate clinical staff available to provide Duty Resuscitation Nurse (DRN) cover on each shift.

At the time of writing this report 90% of clinical trained ward base staff are face fit tested, therefore meeting the local target of 85% and the RAG rate is green.

Information on the number of staff from each ward who are tested is presented in the monthly report. An up to date list of face fit testers is circulated to the Senior Charge Nurses and Lead Nurses on a monthly basis to provide information on staff that have been tested and can provide the necessary cover.

Although the local target only relates to a specific area, across the Hospital there are currently 87% of staff face fit tested this includes staff from all Clinical areas (Psychology, Skye Centre, Wards, Medical and members of the Practice Development Team).

Infection Control Environmental Audit Tool

A scoping exercised was undertaken regarding the merging of the new Infection Control Environmental (ICE) audit and current e-control book Workplace Inspection. However, it was viewed by the Health and Safety Advisor that it was not possible, as the Work Place Inspections were specifically for Health & Safety control books albeit there is duplications within both documents. This will be re-visited in the new year.

The Infection Control Team circulated the ICE audit to the Senior Charge Nurses for completion and feedback with a return date of the 14th November 2022. All 10 wards returned their audits tools for auditing within the agreed timescales.

A database has been developed to monitor audit compliance and this is being populated with data and analysed. Results will be submitted to the Infection Control Group in early 2023.

Product Request Checklist

As part of the HAI Standard 9 the Senior Nurse for Infection Control requested a review of the New Product/Commodity Form, which has been used since 2013. A meeting was organised with Infection Control, Risk Management, Estates, Housekeeping to review what is required, and it was agreed for a checklist to be developed to replace the existing form. The original form was viewed as outdated following COVID 19 and moving forward this will ensure that all relevant individuals are included and advice is sought when purchasing new equipment. This work is still ongoing.

3. COVID19 Activity

To date there have been 116 patients who have tested positive. With 0 cases since last report

HIS Infection Prevention and Control Standards

The Senior Nurse for Infection Control continues to work alongside HIS to ensure that forensic settings are assessed proportionately against the Standards. The Infection Control Team have undertaken a 'self assessment' against the standards and are currently working through area were compliance can be increased.

Future plans

Discussion will take place in Janury 2023 regarding the wider use of facemasks within the State Hospital. This discussion will follow local surveillance on respiratory illness.

4. RECOMMENDATION

The Board is invited to

1. Note the content of this report.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	To provide the Board with specific updates infection control as well as any other areas specified to be of interest to the Board.
Workforce Implications	
Financial Implications	No financial implications identified.
Route To Board Which groups were involved in contributing to the paper and recommendations.	Nursing and AHP Directorate Board requested information.
Risk Assessment (Outline any significant risks and associated mitigation)	Not identified for this report.
Assessment of Impact on Stakeholder Experience	Not identified.
Equality Impact Assessment	Not formally assessed.
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	Not identified as relevant.
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One ✓ There are no privacy implications. □ There are privacy implications, but full DPIA not needed □ There are privacy implications , full DPIA included.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 December 2022
Agenda Reference:	Item No: 10
Sponsoring Director:	Medical Director
Author(s):	PA to Medical Director
Title of Report:	Bed Capacity within The State Hospital and Forensic Network
Purpose of Report	For Noting

1 SITUATION

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

2 BACKGROUND

a) TSH

The following table outlines the high level position from the 1 October 2022 until 30 November 2022.

	MMI	LD	Total
Bed Complement	128	12	140
Staffed Beds	108	12	120
Admissions	5	1	6
Discharges / Transfers	6	0	6
Average Bed Occupancy: Available beds/All beds			92.5% 80.0%

Please note that there were 111 patients as of 30 November 2022 and 15 patients with a primary diagnosis of Learning Disability.

18 patients have been identified for transfer from TSH and 12 have been fully accepted for transfer. We have one MMI patient at TSH under the Exceptional Circumstances clause.

b) TSH Contingency Plan

A contingency plan has been finalised through CMT. This remains as follows:

I Ongoing Actions

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

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

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

c) Forensic Network Capacity

The Board received copies of the Forensic Network's short-, medium- and long-term plans to improve capacity across the forensic estate at its meeting on 25/8/22. These were requested by Scottish Government. A copy of the weekly bed report across the Forensic Network is attached dated 05/12/22 – see Appendix 1. The Orchard Clinic has temporarily reduced its capacity by 7 beds for urgent repairs.

Appendix 1 - bed capacity as at 05.12.22

3 ASSESSMENT

The current bed situation within TSH remains eased but it is recognised that there is a natural variation in the number of referrals and admissions and further pressure is likely in the future unless the medium and long term plans outlined by the Network are progressed. TSH remains closed to exceptional circumstance patients due to workforce issues. The Orchard Clinic's temporary closure of 7 beds for urgent work will cause further pressure across the forensic estate.

4 RECOMMENDATION

The Board is asked to note the report.

MONITORING FORM

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

Paper No. 22/114

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 December 2022
Agenda Reference:	Item No: 12
Sponsoring Director:	Director of Nursing and AHPs
Author(s):	Patients' Advocacy Service Manager
Title of Report:	Patient Advocacy Service 12 Monthly Report
Purpose of Report:	For Noting

1 SITUATION

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

2 BACKGROUND

We will highlight progress made within the service including improvements, achievements, and future plans. We also set out any challenges faced and remedial action taken to overcome these. The following report highlights August 2021-July 2022.

3 ASSESSMENT

August 2021 – July 2022

- Achievements against the Key Performance Indicators (KPI) in the Service Level Agreement this year continue to be mostly met with statistical reporting evidenced in section 4; patient narratives in section 7 and accounts in section 12.
- Full and effective use is being made of the budget allocated by the Hospital for the service.
- 2 Year extension of the Service Level agreement
- The additional recurring £20,000 funding received from the Scottish Government following the introduction of the Patients' Rights Bill continues to assist PAS to offer extra support required with hard-to-reach patients.

- Robust arrangements are in place for the growth, professional development and support of all Advocates and Volunteer Advocates.
- Positive communication between PAS and The State Hospital continues to foster excellent working relationships beneficial to both organisations and patients.
- This year, the amount of contacts and actions PAS completed, increased compared to the same timeframe the previous year.
- We continue to explore how PAS can promote itself as an operation wholly independent from The State Hospital, therefore ensuring we continue to provide independent advocacy to patients.

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

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

4 RECOMMENDATION

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

PATIENTS' ADVOCACY SERVICE

12-Monthly Report

1st August 2021 – 31st July 2022

1 Introduction

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

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

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

The Mental Health (Care and Treatment)(Scotland) Act 2003 establishes the right to access Independent Advocacy for those experiencing a mental disorder. The purpose of this report is to inform and evidence the key performance indicators, stipulated within the Service Level Agreement, by TSH. The report describes how the service provided by PAS has the ability to adapt to the ever-changing needs of the patient population especially with the ongoing issues surrounding Covid-19 and the staffing crisis.

1.1 Highlights of the Year

This report relates to the period August 2021 – July 2022, reflecting on another successful, albeit challenging year, during which we continued to provide an Independent Advocacy service to all patients. Work included this year is as follows.

- The updated recruitment, induction and training materials noted in the previous report were utilised to advertise two advocacy posts and support the new individuals to these roles.

- Created and launched our first PAS website (www.patientsadvocacyservice.scot).
- Continued to support patients during a further period of limited activity due in part to the pandemic and issues with staffing levels in TSH.
- Continued to develop the knowledge and skills of the team by supporting them to attend training and webinars.
- Continued to connect with external advocacy providers including those based in other high secure services in the UK.
- Continued to champion the patient voice by responding to important consultations and partaking in short life working groups relevant to the patient population.
- Increased actions and contacts with patients to meet requirements.
- Updated and improved statistical reporting to highlight the variance of work we complete.

On the 22nd of October 2021 PAS held their 12TH Annual General Meeting (AGM) where we delivered our Annual Report for 2020-2021 via Microsoft Teams due to the restrictions in place at the time.

Although the Independent Forensic Mental Health Review was published in February 2021, we continue to attend relevant short life working groups through the Scottish Government to highlight the patient voice. We are awaiting the Scottish Government recommendations and any changes this may mean for PAS and patients in TSH. Additionally this year, we responded to the Scottish Mental Health Law Review both in general consultation and the forensic specific proposals. As of July 2022 we await the final report and any implications this may have for both PAS and patients in TSH.

2 Governance Arrangements

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

Following discussion with TSH, they agreed an extension to the service level agreement of 2 years meaning we will move to tender in 2024 as this will take us to the end of the contract.

2.1 Finance

The annual cost of the service to the Hospital in the financial year April 2021 - March 2022 was £147,014 which includes recurring funding of £20,000 initially received in April 2012 from the Scottish Government following the introduction of The Patients' Rights (Scotland) Act, 2011. The full financial report can be seen on page 40.

2.2 Committee Membership and Role

The Board of Directors comprises:

- Michael Timmons, Chair
- Heather Baillie, Treasurer
- Innis Scott, Secretary
- Ruth Buchanan
- Daniel Reilly

2.4 Board Meetings

The PAS Board of Directors held 10 Board Meetings during the year and an AGM. The AGM took place online due to restrictions in place at the time as did 8 of the board meetings. We held 2 board meetings in person.

PAS remains committed to supporting our patient representative to meaningfully engage in our board meetings; the patients' voice is invaluable to the service and it is helpful for PAS Board members to hear directly from the patient representative the issues being faced. Our current patient rep has been a member since January 2021 and actively engages in the Board meetings both by videoconferencing and in-person when they are able to be held.

In May 2022 the constitution was updated to reflect an agreement by the PAS board to hold meetings via a mixture of in-person and digital on a bi-monthly basis. The rationale for this change was to reflect the changing nature of the environment, to allow for changes and actions to be taken forward once agreed at board meetings. This has also reduced pressures on TSH who have to provide staff to help host our board meetings with involvement from our patient rep.

2.5 Workforce

To deliver our KPI's we have a small staff team with a variety of areas of expertise. Our knowledge and experience of engaging with patients continues to expand. This allows us to provide a person-centred service for the patient. Securing and retaining skilled employees is challenging in such a unique environment.

As per the last report we had a full staff complement as of July 2021. Over the past year we have lost 1 advocate, which was our newest recruit. In response, we moved again to recruitment and were able to offer a post to our administrator, Charlene Ramzan

following a successful period of volunteering. She has settled in to the role exceptionally well and the patients are delighted to be working with her in a new capacity. With this change we were in a position of recruitment for a new administrator. Following a successful recruitment drive, we employed Julie Coy who is learning the environment and the role of administrator with PAS. At the end of July 2022, we received a resignation from our long term advocate Stephanie Neilson who has decided to return to university to become a mental health nurse. Once again, we are in a period of recruitment but due to the work done on the advert and induction previously, we were able to quickly put the role out to advert.

As of July 2022 the PAS workforce is as follows:

- 1 x part-time Manager 28 hours
- 1 x full-time Advocate 35 hours
- 2 x part-time Advocates 28 hours each
- 1 x part-time Administrator 21 hours

With the covid-19 restrictions remaining in place on office numbers, we were unable to resume the volunteer programme over the last year. However, during this time we have updated the advertising materials along with a DPIA, EQIA and risk assessment to ensure we are in the strongest position possible to re-introduce volunteers to the environment.

2.6 Working Relationships

The PAS Manager maintains regular contact with hospital professionals including the PCIL, PCIT, Lead Nurses, Senior Charge Nurses and Complaints Officer. This ensures effective communication, collaboration and joint working whereby issues are dealt with promptly and locally. In addition, the PAS manager attends other relevant meetings throughout the Hospital and attends each PAS Board meeting along with a report highlighting the work completed between meetings.

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

At the end of this reporting period we scheduled a meeting with the chief executive and the director of nursing. This meeting was suggested by PAS board members as being beneficial to discuss the ongoing work in relation to the ongoing challenges with staffing levels. Following the successful meeting, it was agreed for a PAS board member, PAS manager, along with the chief executive and director of nursing to meet on a bi-monthly basis to share relevant updates and discuss any issues. It was felt this was a beneficial meeting to link both organisations and allows the PAS board to be engaged with the hospital in another format.

2.7 Training

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

Additional training completed this year includes:

- Adults with Incapacity – Foundation
- Addictions Webinar – Forensic Network
- Clinical Forum: Expert Reviews of Prisons
- SIAA Peer Support – Pause for Thought
- The Long-Term Effects of Child Sexual Abuse: Social, Psychological and Criminological Sequelae Confirmation Webinar
- Records Management Training
- Dementia Training
- SCVO – Introduction to People Management Training
- Human Rights and Mental Health Webinar
- Communication and Dementia Training
- SIAA Leadership and Management Course
- Criminal Law and the CRPD – Vulnerability, Disability and Crime
- Victims and Trauma: The Impact of Trauma Training
- Performance Management Webinar
- MWC Scotland: Mental Health support in Scotland's prisons
- SIAA: SCCRC Information Session

We actively encourage staff and volunteers to undertake training and continued professional development. All staff have a learning plan identified where they are able to highlight training needs, analysed on an annual basis.

2.8 Policies and Procedures

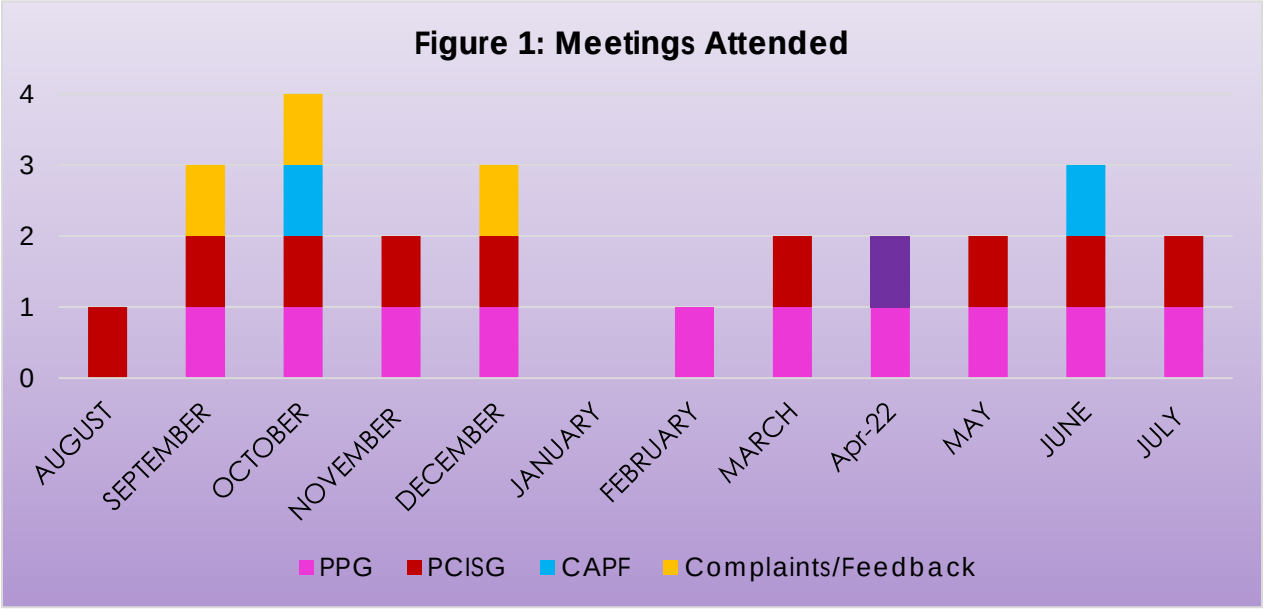
Policies for PAS remain integral to the service operating effectively for both staff and patients. We adhere to all TSH policies and PAS specific policies continue to be reviewed when necessary, ensuring they are GDPR and data protection compliant. We continue to increase the number of policies which have been equality impact assessed.

2.9 Participation / Integration

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

- Person Centered Improvement Steering Group
- Patient Partnership Group
- Child & Adult Protection Forum
- Complaints and Feedback
- Meetings with the Complaints Team to review practice
- TSH Seminar – TSH in 2022
- Patient Groups via Virtual Platforms
- Forensic Network Special Research Interest Group

The graph below highlights the internal groups we attended.



We also attended external events including:

- SIAA Roundtable – Collective Advocacy
- SIAA Managers Group
- MHTS Advocacy reference group
- Independent Review into the Delivery of Forensic Mental Health Services
- Reforming the Delivery of Forensic Mental Health Services to Improve Outcomes for People

PAS remains involved with the Scottish Independent Advocacy Alliance (SIAA) providing the distinctive perspective of patients within a high secure environment ensuring this is

included in any developmental work. The events attended by PAS over the reporting period can be seen above.

Consultations both internal and external we have responded to over the reporting period include:

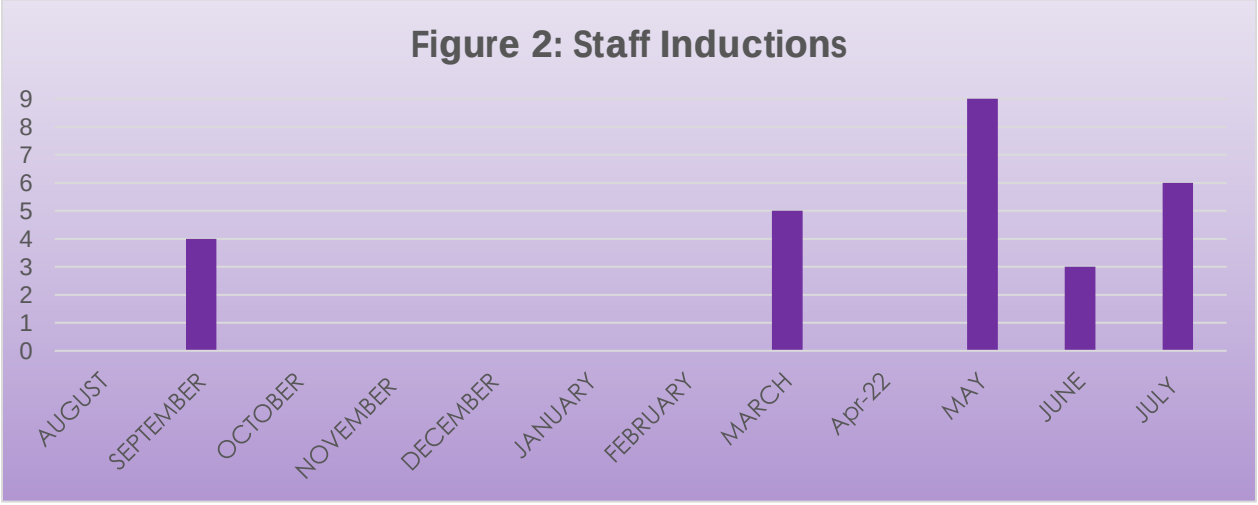
- Scottish Mental Health Law Review Consultation
- Scottish Mental Health Review – Raising Complaints in the Mental Health System
- Scottish Mental Health Law Review – Forensic Proposals
- SIAA Members Survey
- TSH Patient Funds
- TSH Patients Mail Policy
- TSH Duty of Candour
- TSH Covid-19 Staff Engagement Survey
- TSH Corporate Parenting Plan

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

External working groups included:

- Mental Health Tribunal Service Users and Carers Group

We are involved in the induction process of new TSH staff, including students from various departments. Following the successful student nurse inductions which started in the previous reporting period, we have continued this practice. The graph below shows on a monthly basis the inductions provided to new staff. These include student nurses, student occupational therapists, new social workers and health records staff. We hope to expand these inductions over the next reporting period to include new nursing staff.



3 Patient Questionnaire

The patient questionnaire as noted in the SLA as a requirement was this year devised with two patient representatives and input from the Person Centred Improvement Team (PCIT). We were able to fully update the questionnaire with the aim of eliciting more constructive feedback. Once agreed, the PCIT distributed the easy read questionnaire to all patients and supported some to complete in November 2021. The PCIT collated the questionnaires and provided PAS with a spreadsheet containing the data. PAS then used this data to create a report. There were 116 patients in the hospital at the time and 48 patients completed the questionnaire. This is a response rate of 41%.

Actions Resulting from the Questionnaire

PAS are extremely grateful to both the patients who took the time to complete the questionnaire, as well as the input from patients and the PCIT in organising the questionnaire, distribution and collation.

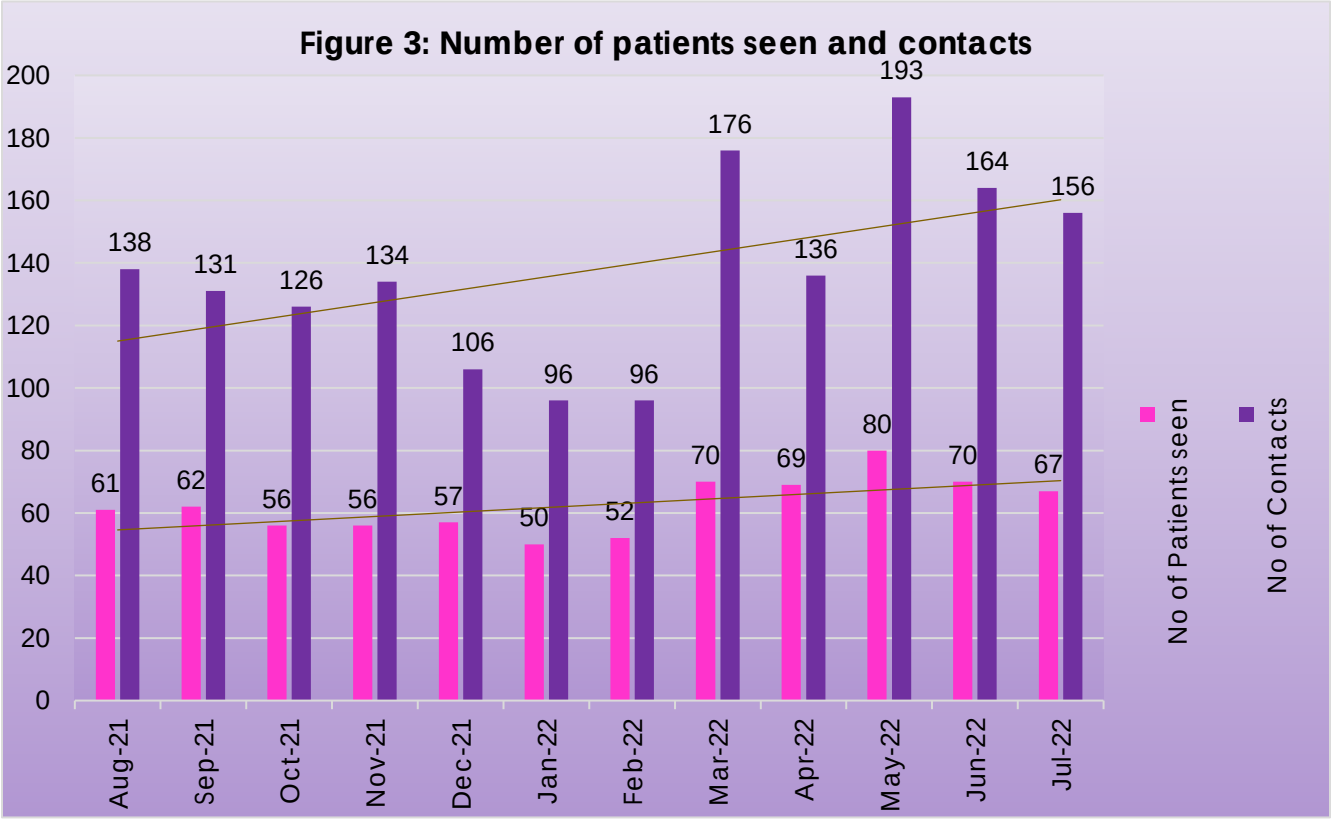
The board and staff discussed the results and some of the points important to address include:

- Making PAS more visible as an independent organisation. This could include the use of a different coloured lanyard, badge or clothing. Inclusion within the patient poster on the wards and within the patient pack we wish to provide to all new patients to the hospital about advocacy and our role.
- Exploring the options for the use of the Skye Centre for meeting with patients.
- Exploring the attendance at more PPG meetings.
- Updating the advocacy poster in the wards.

We attended the PPG to inform patients of the report and this was also disseminated through the Person Centred Improvement Steering Group. Additionally, a poster was created and placed in all wards to inform all patients of the outcomes and the actions we planned to take. A copy of this poster can be seen in Appendix 1.

4 Key Performance Indicators

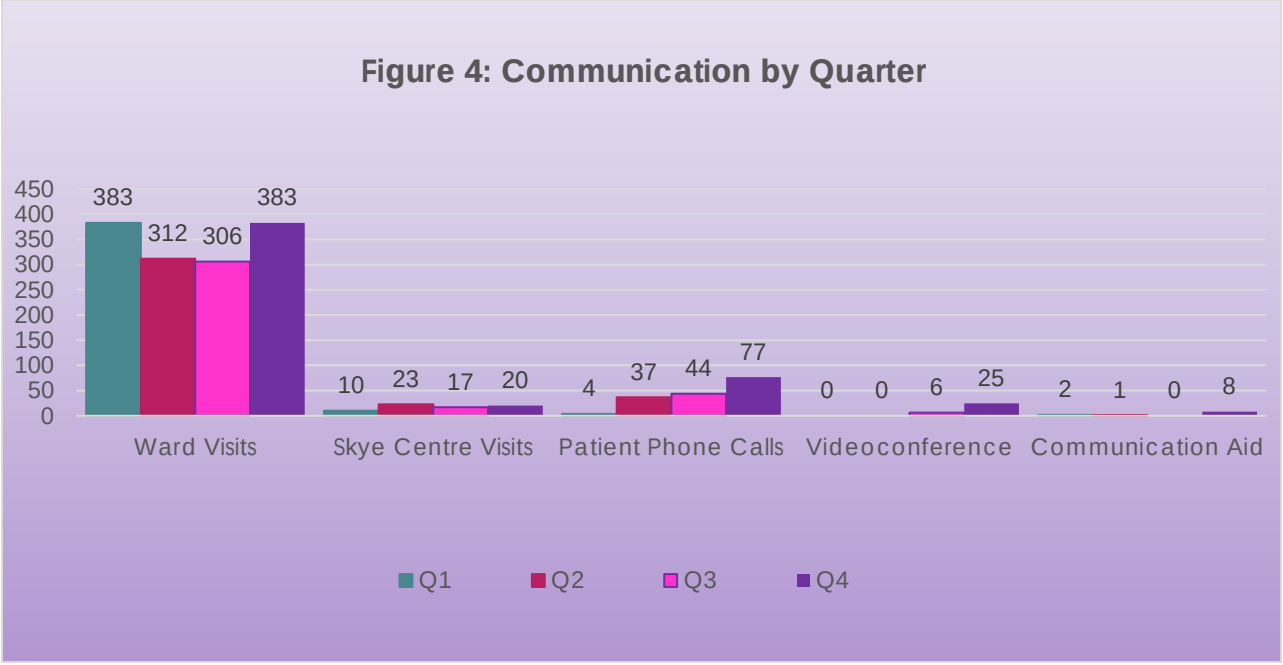
4.1 Contact



Overall we made 1652 contacts with 142 patients. All patients within TSH are seen by PAS a minimum of twice per year as we ensure each patient is approached prior to their case review, of which they have 2 per year. The average number of contacts per patient throughout the period was 14. These figures include 28 patients transferred to medium secure units, returned to prison, or discharged to the court/community. There were also 26 admissions during this period.

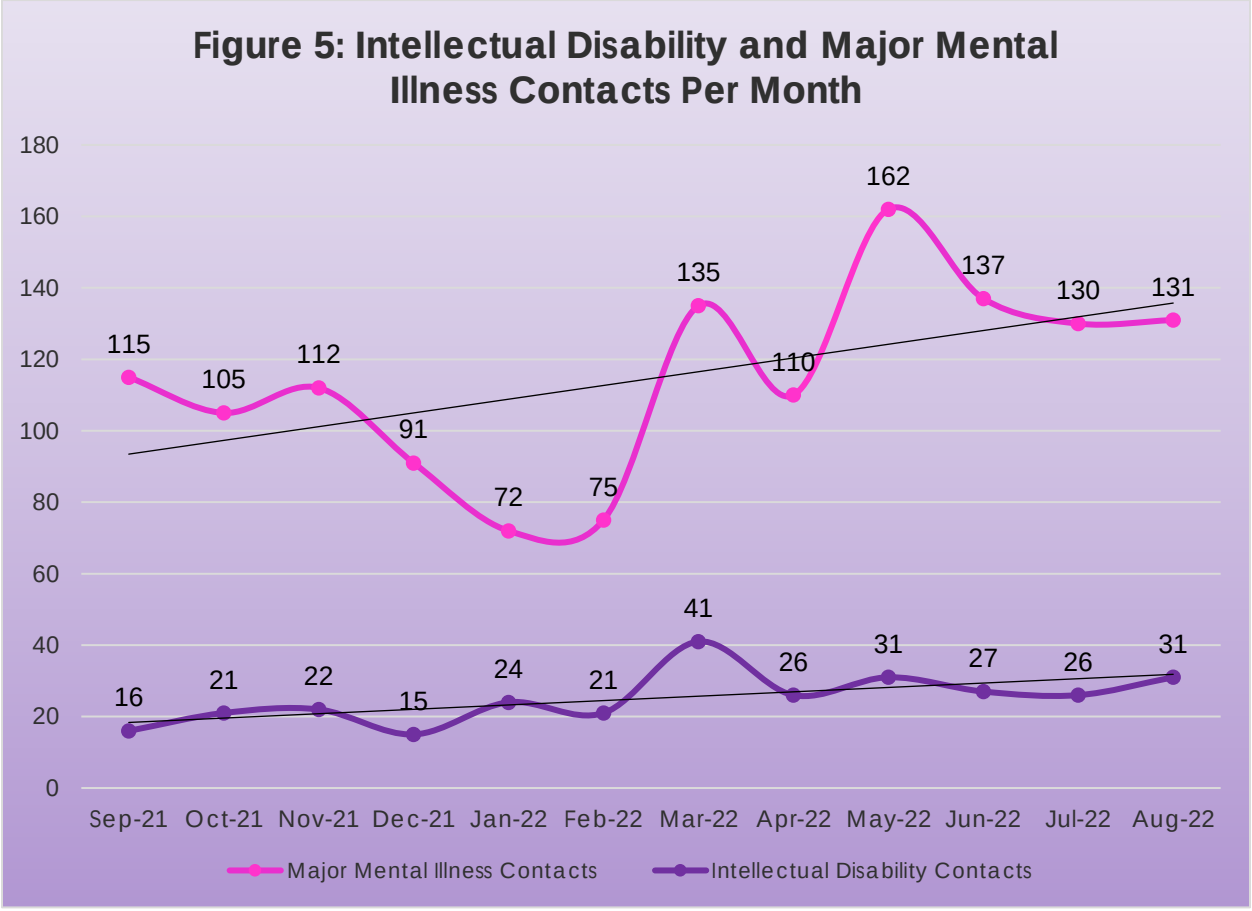
As can be seen by the trend lines, both the number of contacts and the patients seen gradually increased across the year. This may be attributable to the fact that from February 2022 PAS was fully staffed and therefore had greater capacity to spend time on the wards which was not the case from August 2021 where there was a period of long term sickness and a vacancy from November until January 2022. During this period of reduced staffing we ensured the service delivered to patients remained as consistent and thorough as possible.

4.2 Communication by Quarter



The graph above shows how we communicated with patients by quarter. This highlights the diverse ways we interact with our patients. As shown, the majority of our contacts are ward based, however patient phone calls have steadily increased across the year. This is partly due to new ways of working and faster resolve to patient queries. Videoconferencing (VC) has also increased between the last 2 quarters, this is partially due to it being newly introduced to be recorded in our statistics and includes communications by VC such as us attending CPA's in this manner or meetings with solicitors for example. As noted in our previous report, we have now included how many times a communication aid has been utilised with a patient to show the varying methods of communication. At present we mostly utilise an interpreter with some of our patients however, we also hope to be using talking mats in the coming year and this will also be included in future reports.

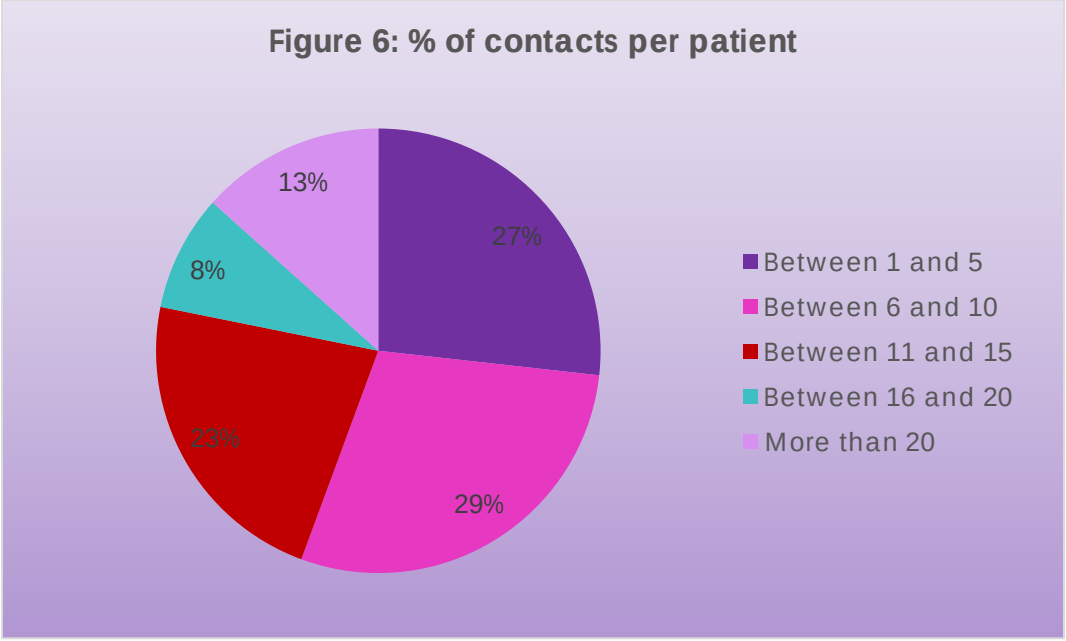
4.3 Major Mental Illness and Intellectual Disability Contacts



The above graph is new reporting for this period. Within the service level agreement it notes reporting on the number of contacts specifically with patients identified as having an intellectual disability (ID) and the types of intervention provided. Shown in the graph above are the number of contacts per month for those with an intellectual disability and those with major mental illness (MMI). As can be seen from the trend lines there was a steady increase across the year for both groups.

Of particular note for the intellectual disability group was March 2022. At this time, majority of the contacts related to legal work such as supporting a patient to engage the services of a solicitor, facilitating contact with a solicitor or attending solicitor meetings. In addition there were discussions surrounding CPA's, tribunals and parole boards. Alongside the legal element, there were conversations regarding a patients' treatment, complaints, discussing options along with 1 patient who has a weekly meeting for relationship building. There was no one individual patient which was the primary beneficiary of these contacts, instead there was an even spread across the population which seemed to encompass a lot of legal discussions at this time.

4.4 Contacts per Patient



This graph highlights 27% of patients were visited by an advocate between 1-5 times. All categories for this graph were reduced from the previous report aside from those seen more than 20 times which rose from 5% to 13%. We continue to monitor patient contacts to ensure these are reflective of the service we provide. Some patients require more support than others, this is particularly true of our intellectual disability patient group and new admissions to the Hospital.

One of the factors which may have influenced this change has been the introduction of a weekly drop in to our intellectual disability group. Additionally, our new admissions have been more challenging in terms of requiring more frequent contact, which as a team, we have agreed we will provide a weekly contact until their first CPA which is around 12 weeks after admission. Finally, as shown previously, phone contact has been used more often which is a quicker process than advocates visiting the wards. Particularly for local resolution, this method is beneficial for both patients and PAS, however it has meant an increase in contact for some of the patient group.

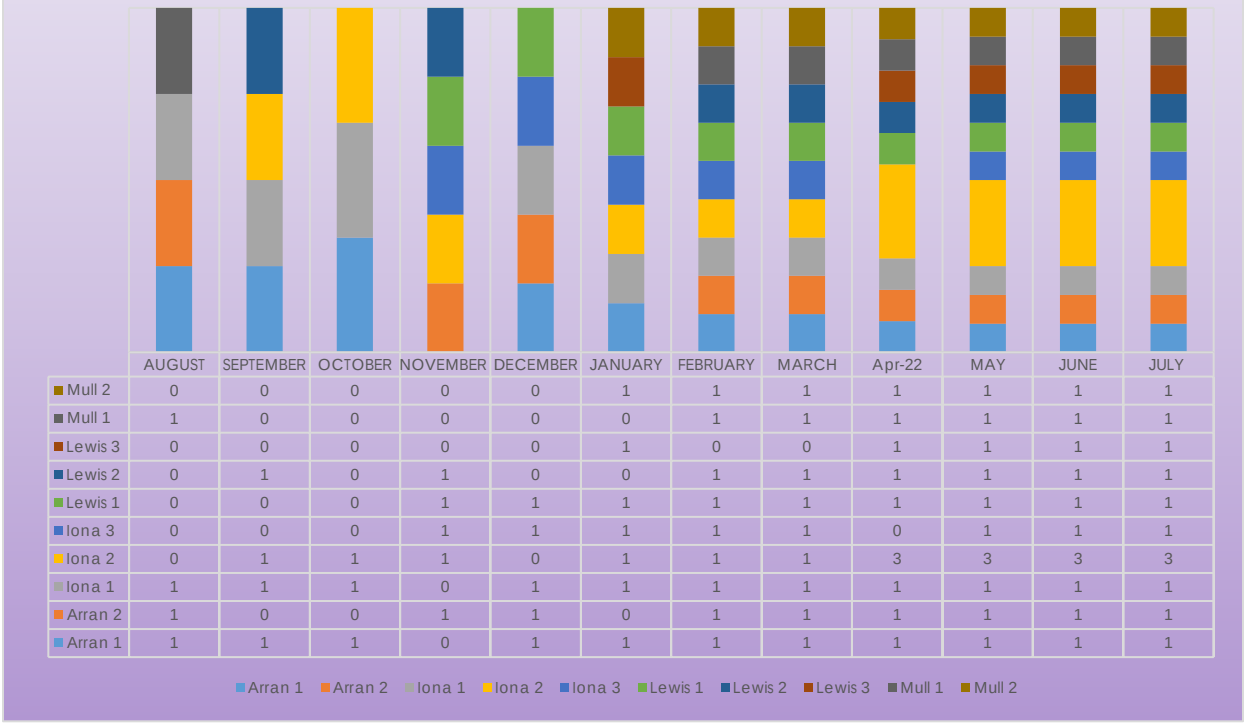
4.5 Ward Drop In

The service level agreement requires PAS to provide a monthly drop-in to each ward. The following graph reflects this target was not met during August 2021-July 2022. This is partly due to covid-19 restrictions and TSH staffing difficulties over the past year where it has been challenging to get on the wards at times.

As shown below, in August 2021 we did not complete a drop in in Iona 2, the intellectual disability ward, this is due to a slightly higher number of contacts throughout the month. In December 2021, the advocate who predominantly works in Iona 2 was absent over the Christmas period which may have impacted the ability to complete a drop in. Following the recognition the intellectual disability group require more regular contact and reassurance, in April 2022 we introduced a weekly drop in. We worked with nursing staff to identify a suitable time when most of the patients were present on the ward. Consistency is provided for patients and more efficiency of the PAS service. This new practice has been beneficial and we will continue this moving forward as long as time allows.

The ward drop in model has changed over the years. With the loss of the Skye Centre drop in, we are finding ourselves on the ward more often. Given the upcoming changes to the clinical model, we have added the drop in as an action point for discussion and amendment, as we may wish to utilise the model of a weekly drop in session for some wards given the higher activity in these areas.

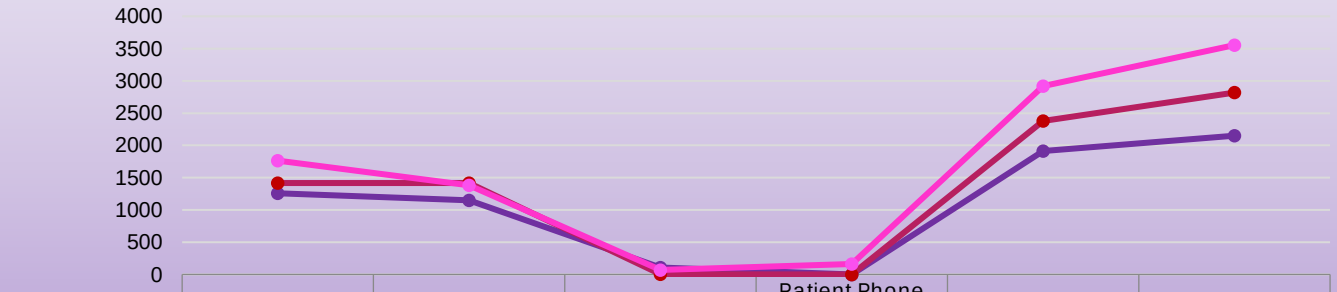
Figure 7: Ward Drop In



	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	JANUARY	FEBRUARY	MARCH	Apr-22	MAY	JUNE	JULY
Mull 2	0	0	0	0	0	1	1	1	1	1	1	1
Mull 1	1	0	0	0	0	0	1	1	1	1	1	1
Lewis 3	0	0	0	0	0	1	0	0	1	1	1	1
Lewis 2	0	1	0	1	0	0	1	1	1	1	1	1
Lewis 1	0	0	0	1	1	1	1	1	1	1	1	1
Iona 3	0	0	0	1	1	1	1	1	0	1	1	1
Iona 2	0	1	1	1	0	1	1	1	3	3	3	3
Iona 1	1	1	1	0	1	1	1	1	1	1	1	1
Arran 2	1	0	0	1	1	0	1	1	1	1	1	1
Arran 1	1	1	1	0	1	1	1	1	1	1	1	1

4.6 3 Year Comparison (2019-2020, 2020-2021, 2021-2022)

Figure 8: KPI 3-Yearly Comparison



	No of Contacts	Ward Visits	Skye Centre Visits	Patient Phone Calls	Issues	Actions
2019-2020	1256	1148	108	0	1912	2150
2020-2021	1416	1415	1	0	2381	2818
2021-2022	1762	1384	70	162	2917	3554

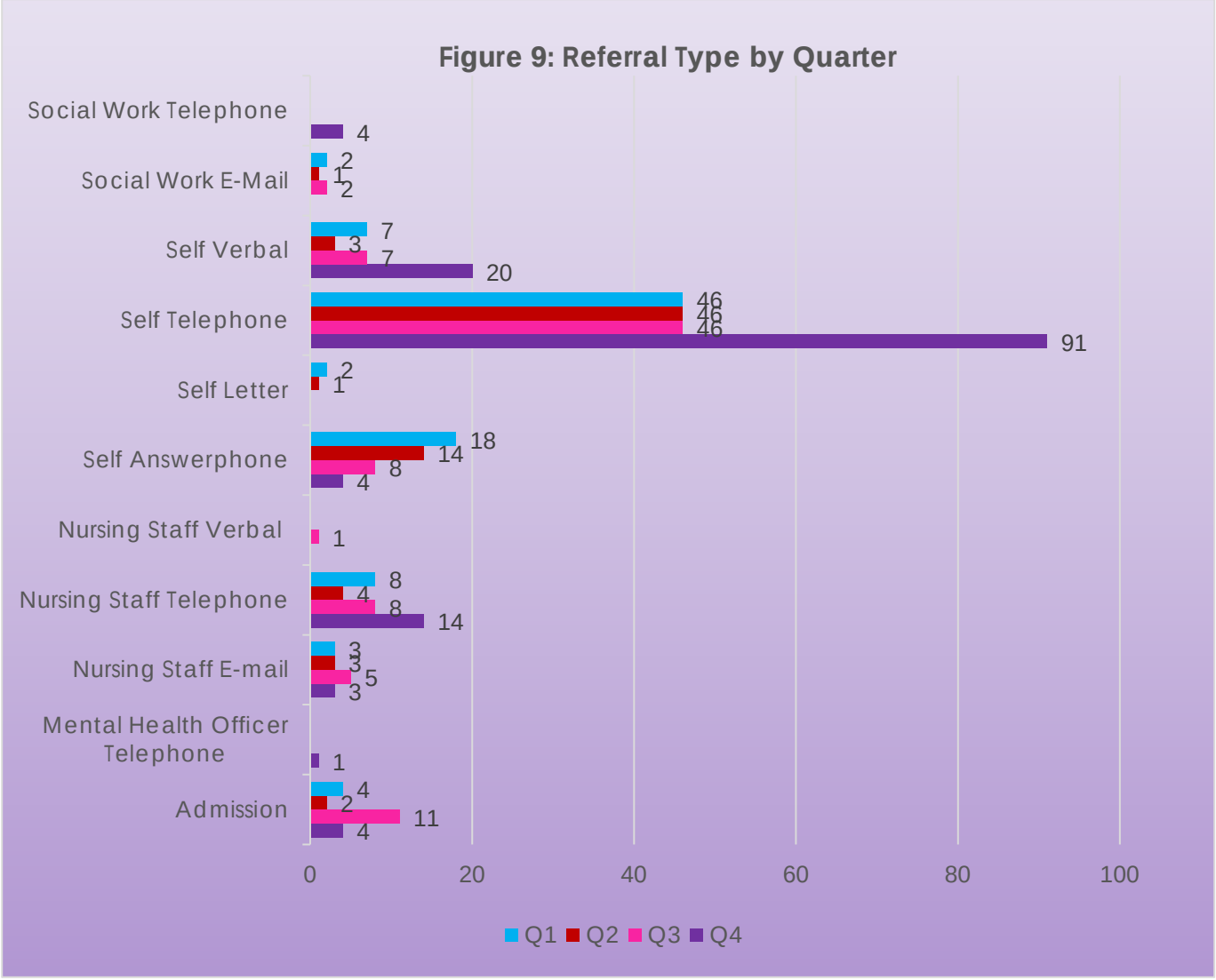
The figures in the above graph show a steady increase over the past 3 reporting periods for all categories aside from Skye Centre Visits which may be attributable to the loss of the Skye Centre drop in, in 2018. However, the pandemic altered our practice and with the closure of the Skye Centre for a period of time, this changed how we visit with patients. It is encouraging however to see these levels are starting to rise closer to pre-pandemic levels.

We began recording the number of phone calls specifically with patients so we could identify how much contact we had with patients as well as internal and external organisations to provide more in depth data. This began in October 2021 and is specifically for phone calls where advocacy support has been provided. As shown however, majority of our contact remains on ward.

The issues have increased steadily across the years, this could partly be due to better reporting but also is in line with the increased contact we have had with patients. Additionally, staff working with patients have been doing so for a number of years which impacts how open patients tend to be with advocates in seeking support for issues they are facing.

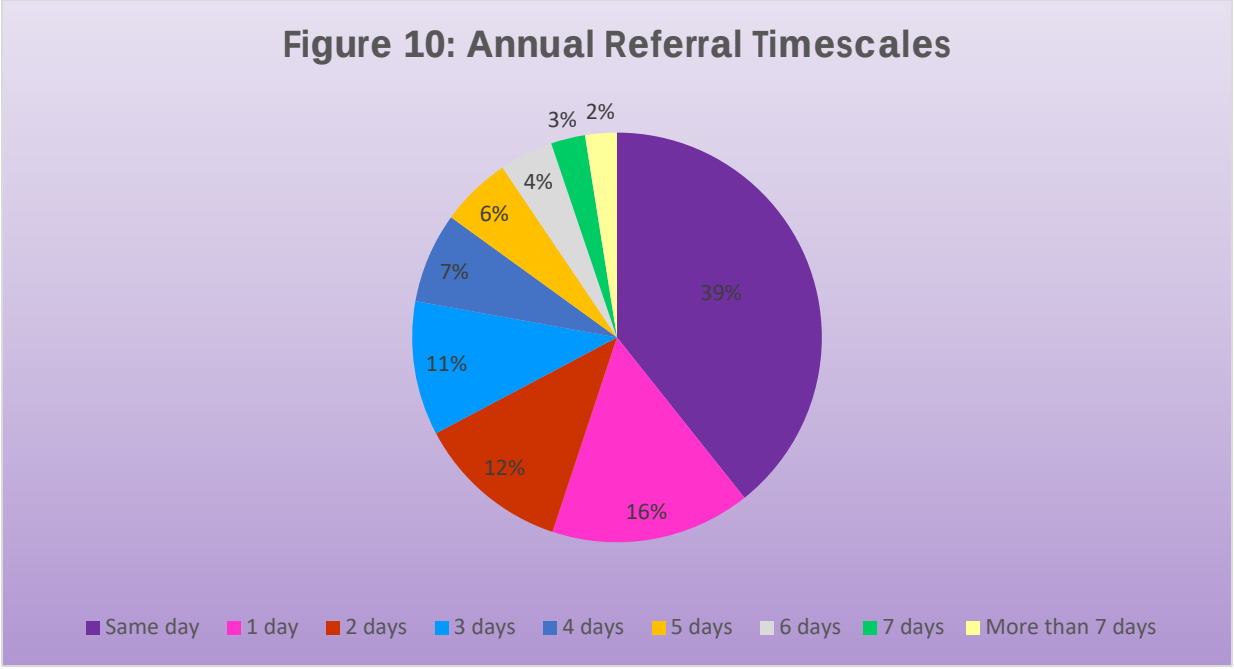
Our actions have continued to increase across the 3 year period and have significantly increased from 2019-2020. Again, this may be in part to more thorough recording of the work we do, along with increased patient contact and trusting relationships we have with patients. Some of the increases within the action category are the emails being sent. This allows us to quickly resolve a number of queries and is reflective of the changing nature of communication. We are also starting to see the number of meetings we support a patient in, outside of their legal meetings, return to pre-pandemic levels. These meetings include support during assessments with other services and solicitor meetings. We have noted an increase in the amount of CPA's, tribunals and parole boards which patients request support, with very few declining this service. One of the other notable increases we have had is the discussion with staff outside of a telephone call or email which, again offers quick resolve to issues a patient may be facing.

4.7 Formal Referral Routes



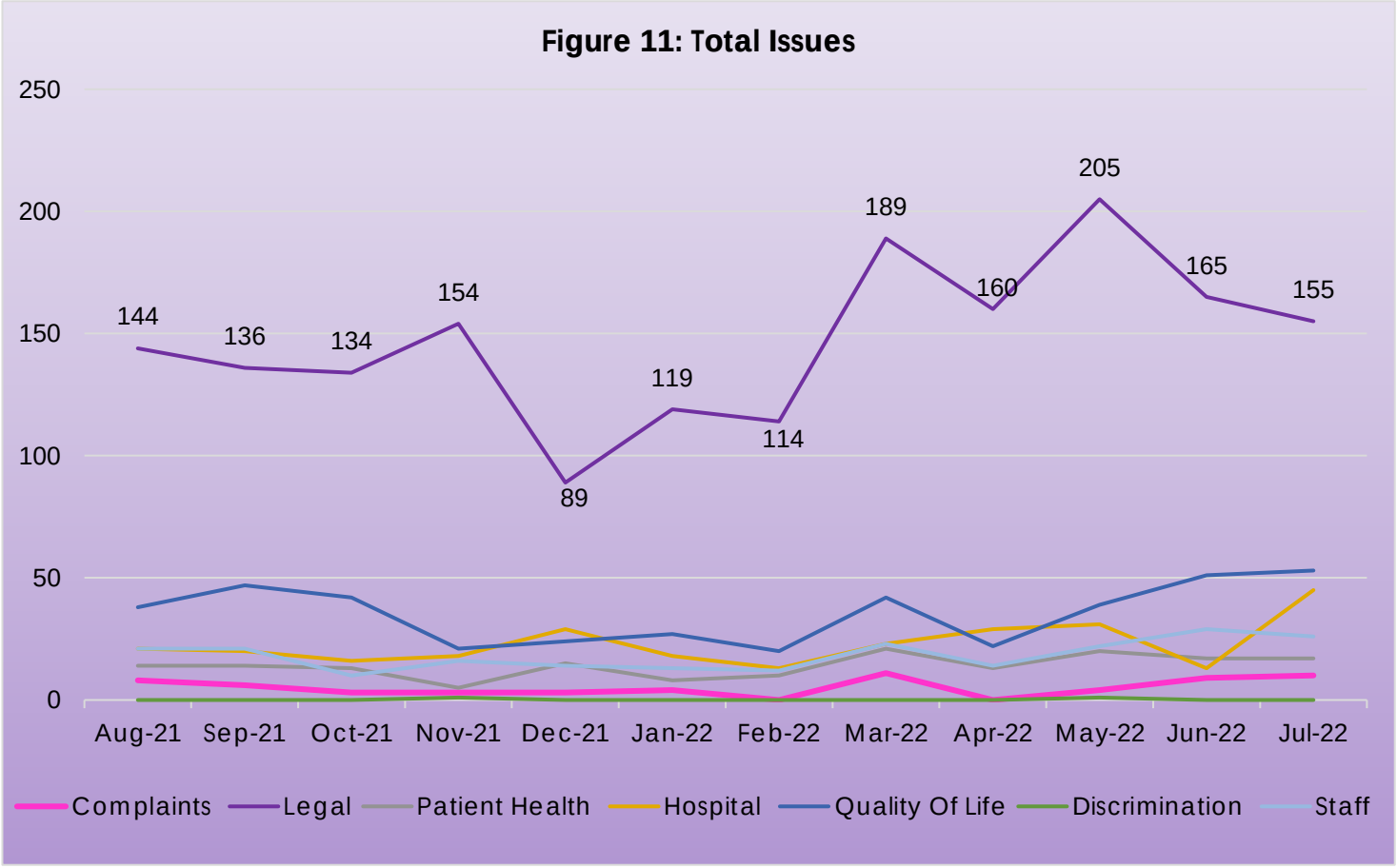
The above statistics relate to formal requests to see an Advocate by quarter. 81% of referrals came from patients themselves via the PAS free phone or via discussion with an advocate. This was an increase of 7% from the previous report. Hospital staff continue to be vital for us to provide support to patients, with a further 19% of referrals coming from nursing staff and social work, telephone calls and emails, a reduction of 7%. However, it is positive to see a further increase in patients reaching out to advocacy independently for support.

4.8 Patient Referral Timescales



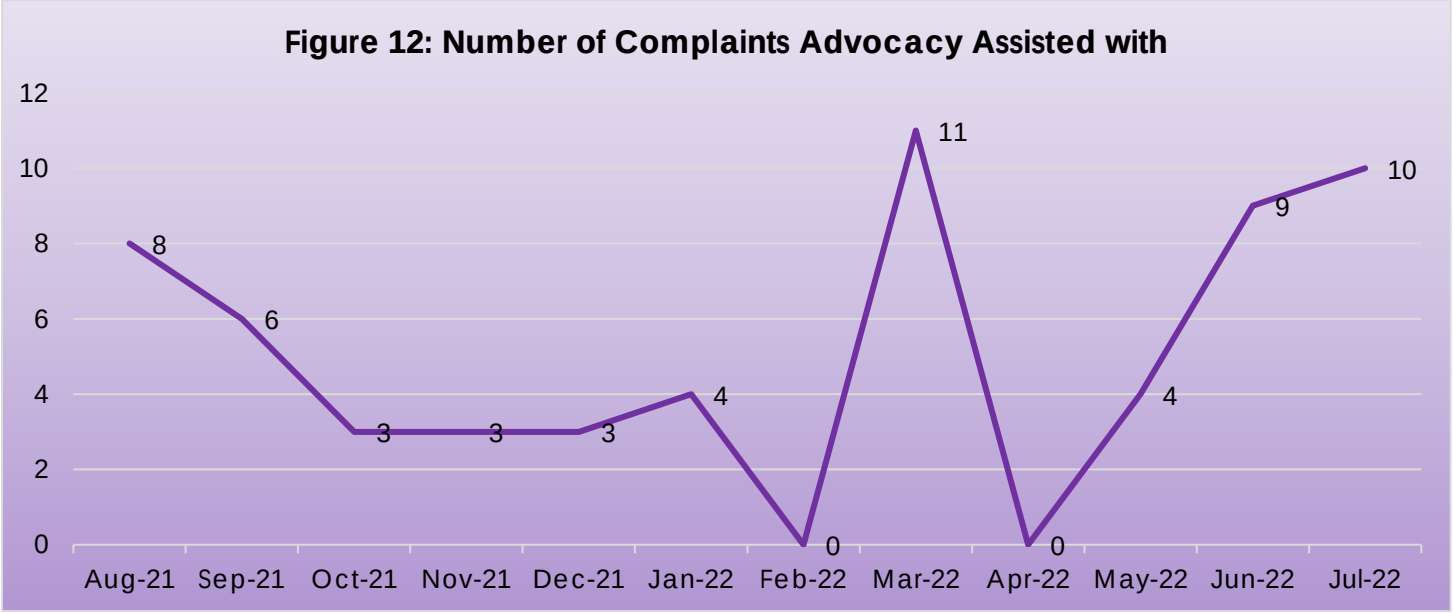
This graph relates to how quickly PAS responded to requests to see an advocate. As shown, 39% were responded to on the same day with a further 28% seen within 2 days. This highlights 67% of patients were responded to within a 2 working day period making up the majority of referrals. This is the same as the previous reporting period and shows consistency of our fast responses to patients. Those patients seen after a 7 working day period remained at 2% and continued to be related to either new admissions who nursing staff deemed it too risky to visit or patients in isolation who were unable to be seen therefore out with the control of PAS. It also encompasses those patients who requested advocacy support but wished to wait until their designated advocate was back on site from annual leave or isolation. All patients were offered another advocate to visit them or we engaged with nursing staff to keep updated of how a patient was doing and whether they were able to be visited.

4.9 Issues



The service dealt with 2917 issues which is an increase from 2381 (up 536 or 22.5%) in the same period from August 2020 - July 2021; Legal issues remain a majority contributor with 1764 issues (60% of the total). Hospital issues, which cover any hospital-based issue including policies and procedures; ward or hub moves and changes to a patient's clinical team account for a further 9%, a 2% decrease from the last report. Lastly, quality of life issues relating to food, family, and grounds access etc. account for 14%, an increase of 2% from the last report.

4.10 Complaints and Outcomes



PAS recorded 55 complaints submitted at stage 1 which is a notable increase from 19 in the previous reporting period. These complaints related to a variety of factors however, the most frequent complaints surrounded quality of life issues such as TSH staff shortages meaning wards and placements were closed, protein bars no longer being permitted, issues with rehab outings, sky tv and the fairness of use. 5 were resolved locally and there were 43 discussions of a potential complaint also recorded. These discussions encompass informing patients of their right to submit a complaint, discussions about the process but which do not get to the stage of a complaint being submitted.

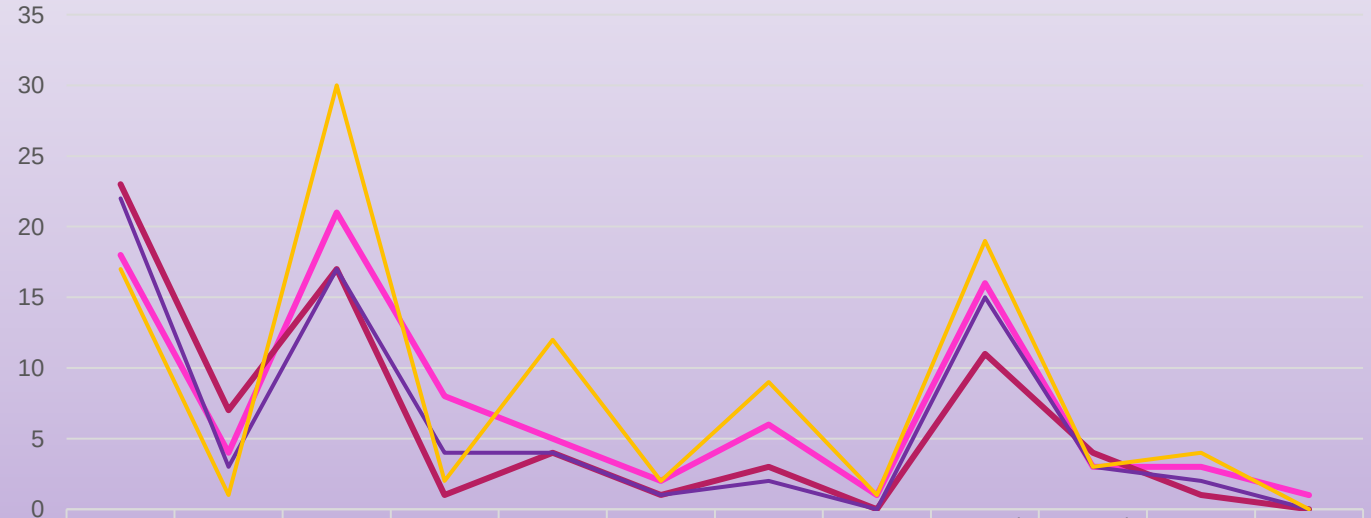
4.10.1 Complaint Outcomes

Action	***Patient Outcome***	***Hospital Outcome***	***Total***
Discussion about a complaint	Patient able to express dissatisfaction and discuss their options in line with TSH Policy.	Locally resolved by complaint not being submitted. Patients' rights met.	43
Formal Complaint submitted	Patients' dissatisfaction expressed in line with TSH policy.	Patients' right to make a complaint upheld.	55

4.11 Legal Activity and Outcomes

Activity classified as legal is associated with support and attendance at formal meetings with patients, such as Care Programme Approach meetings (CPA), Adult Support & Protection Investigation (ASPI), Mental Health Tribunals, Parole Boards and Solicitor meetings with the patient; all of which require to support prior, during and following the meeting.

Figure 13: Legal Meetings



	Annual CPA's Attended	Annual CPA's Declined	Intermediate CPA's Attended	Intermediate CPA's Declined	Discharge CPA's Attended	Discharge CPA's Declined	Admission CPA's Attended	Admission CPA's Declined	Mental Health Tribunals Attended	Mental Health Tribunals Declined	Parole Boards Attended	Parole Boards Declined
Q1	18	4	21	8	5	2	6	1	16	3	3	1
Q2	23	7	17	1	4	1	3	0	11	4	1	0
Q3	22	3	17	4	4	1	2	0	15	3	2	0
Q4	17	1	30	2	12	2	9	1	19	3	4	0

Q1 Q2 Q3 Q4

As noted above, we attended the vast majority of legal meetings throughout the reporting period. Of the 138 meetings, PAS supported patients' either by attending with them or on their behalf. Out of the 333 meetings, PAS was present at 84%. Those who declined gave reasons such as them not feeling as if there was any need to attend as they knew where they were at in their progress and feeling like they were sufficiently able to advocate for themselves.

4.11.1 Care Programme Approach Outcomes

The following table highlights the patient and hospital outcomes relating to care programme approach (CPA) meetings with further insight in to the volume of work included pre and post CPA.

Action	***Patient Outcome***	***Hospital Outcome***	***Total***
Pre-discussion to Admission CPA	Patient supported to understand the process of a CPA, what is involved, who will be in attendance, support to formulate questions and informed of their options regarding attendance.	Patients' rights to independent support upheld. Patients fully informed of the procedure of a CPA saving staff the time of discussing this information.	26
Attendance at admission CPA	Patients fully aware of what is being discussed at the CPA by attending in person or by having advocacy representation on their behalf.	Patient involvement in the CPA process ensuring patient centred care and accessing their rights to independent support in line with the Mental Health Act.	20
Reflective Discussion separate to admission CPA	Supported to fully understand contents of the CPA, the actions to be taken and plans for the next 6 months.	Ensuring patient understanding of the CPA, reaffirming of actions to be taken saving staff time disseminating this information.	9
Declined advocacy support at admission CPA	Having the choice to decline advocacy support following discussion of the admission CPA.	Patients right to independent support upheld and autonomy in decision making.	2
Discussion prior to Annual or Intermediate CPA	Patient supported to prepare for a CPA by discussing the format, formulating questions, writing a statement and deciding on their attendance.	Patient centred care ensuring patient involvement in CPA process.	236
Attendance at Annual or Intermediate CPA	Patient and/or advocacy attendance at the CPA. Ensuring the patient voice is heard and questions answered.	Patient involvement in the CPA process ensuring patient centred care and accessing their rights to independent support in line with the Mental Health Act.	166
Reflective Discussion separate to the Annual or Intermediate CPA	Supported to fully understand the content of the CPA. If not in attendance, ensuring they are aware of discussions and actions to be taken.	Ensuring patient understanding of the CPA, reaffirming of actions to be taken saving staff time disseminating this information.	64

Declined advocacy support at Annual or Intermediate CPA	Patient approached and discussed the CPA process ensuring their right to independent support. Making the choice to decline advocacy support at the meeting.	Patient rights to independent support upheld and autonomy in decision making.	29
Pre-Discussion to Transfer/Discharge CPA	Patient supported to prepare for a CPA by discussing the format, formulating questions, writing a statement and deciding on their attendance.	Patient centred care ensuring patient involvement in CPA process.	41
Attendance at Transfer/Discharge CPA	Patient and/or advocacy attendance at the CPA. Ensuring the patient voice is heard and questions answered.	Patient involvement in the CPA process ensuring patient centred care and accessing their rights to independent support in line with the Mental Health Act.	25
Reflective Discussion separate to Transfer/Discharge CPA	Understanding the content of the CPA and plans for their transfer.	Ensuring patient understanding of the CPA, reaffirming of actions to be taken saving staff time of disseminating this information.	9
Declined Advocacy Attendance at Transfer/Discharge CPA	Patient able to self-advocate and make an autonomous choice to decline support.	Patients right to independent support upheld and autonomy in decision making.	6

4.11.2 Mental Health Tribunal Outcomes

The following table shows the outcomes relating to Mental Health Tribunals alongside the pre and post discussions which take place to ensure the patient understands their rights and potential outcomes.

Action	***Patient Outcome***	***Hospital Outcome***	***Total***
Pre-discussion to Mental Health Tribunal	Patients provided with verbal and written information ensuring they understand their legal rights and the process of the Mental Health Tribunal. Supported to actively write a statement if they wish.	Patients informed and supported with their legal rights i.e., their right to a solicitor and support from Advocacy in line with the Mental Health Act.	153

Attendance at Mental Health Tribunal	Patients supported to attend the mental health tribunal or have their voice heard through advocacy attendance in their absence.	Patients' legal rights to independent support met. Patient involvement in their care.	61
Reflective discussion after the Mental Health Tribunal	Patients supported to understand the outcomes of a tribunal and their legal rights following.	Patient supported to understand their rights and the outcomes saving staff time sharing this information.	19
Declined advocacy support at a Mental Health Tribunal	Able to make an autonomous decision and attend with their solicitor or had no challenges and declined all attendance.	Patient supported to understand their rights and make a choice.	14

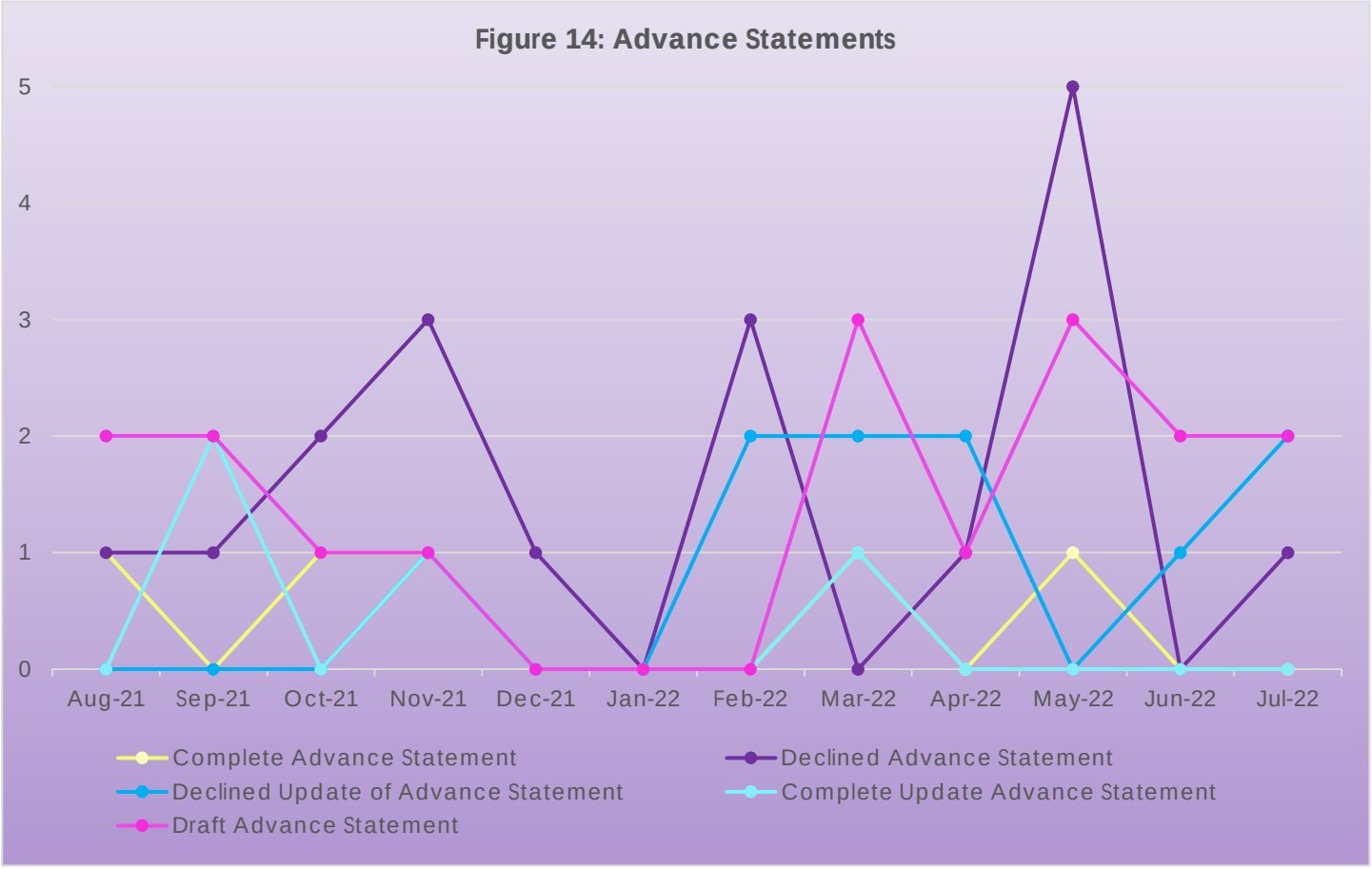
4.11.3 Other Legal Outcomes

This final table highlights the outcomes relating to other legal matter such as Adult Support and Protection (ASP), Parole Boards and attending meetings with solicitors.

Action	***Patient Outcome***	***Hospital Outcome***	***Total***
New Admissions	Patient is informed of the role of Advocacy, their legal rights and how we can support them through their care and treatment.	Legal obligation to provide Advocacy is met as per the Mental Health Act.	26
Supported during a meeting	Patient supported by Advocacy to attend meeting and express their views.	Patients supported as per their right to have Advocacy support as per the Mental Health Act.	5 Meetings with solicitor
Parole Board	Patients provided information regarding their legal rights and the process of the Parole Board Hearing. Ongoing discussion with patients to ascertain levels of understanding and support accordingly. Statement written and submitted in advance if desired.	Patients informed and supported with their legal rights i.e., their right to a solicitor and support from Advocacy.	29 Pre-Discussions 6 Reflective Discussions 10 Attended 1 Declined

Adult Support and Protection	ASP referral made when patient feels or is deemed at risk. Advocacy support to attend the meeting.	Hospital fulfilling legal obligation to support patients through ASP process.	5 Discussions 4 Attended

4.12 Advance Statements



The graph above shows our activity relating to advance statements each month throughout the reporting period. Over all we supported 5 patients who did not have an advance statement to write one, updated a further 5 to be more up to date with a patients' wishes and had 103 discussions about what an advance statement is and its purpose.

4.12.1 Advance Statement Outcomes

The table below shows the outcomes for both the patient and hospital of this input from PAS.

Action	*Patient Outcome*	*Hospital Outcome*	*Total*
Advance Statement Completed	Patient's wishes expressed regarding future care and treatment giving a guarantee the clinical team will take these into account.	Fulfilling legal obligation, providing knowledge of Advance Statements and support to complete these. Advance Statements are person centred, considering patient's wishes. Accurately recording and storing Advance Statements with medical records.	5 New 5 Updated 103 Discussions

5 Progress to Actions of the Last Report

Action	**Outcome**
Organisational:	
We aim to recruit further Board Members and an additional Patient representative to ensure a variety of expertise and experiences.	Ongoing. The advert remains live on Volunteer Scotland where we respond to requests. We plan to recruit an additional patient representative.
Volunteers, we aim to recruit new members to meet the conditions as set out in the SLA.	Ongoing - Training programme and advertising materials updated. Once covid restrictions are reduced we will resume this programme.
Further expand our knowledge by maintaining current training and continuing to attend relevant courses and webinars.	Ongoing – We have attended several training sessions and webinars and continue to attend these when they are available.
Organise the AGM with diversity in speakers.	Ongoing – Our AGM during this reporting period was held online. We hope to secure external speakers in the coming years.

Service:	
Our impact reporting, this will work in tandem with restructuring our reports.	Ongoing – We have updated our reports significantly from previous years and continue to receive feedback to enhance these. We are collecting verbal feedback to greater highlight advocacy impact.
The patient voice, we will continue to respond to consultations as necessary to highlight those marginalised in the forensic mental health system.	Ongoing – We have responded to 3 national consultations this year, 1 SIAA consultation and 5 TSH policy consultations. We will continue to champion the unique voice of patients in TSH when opportunities present.
The annual patient questionnaire, in conjunction with the PPG we will update to allow greater scope of feedback.	The updated questionnaire was completed in November 2021 with responses received by January 2022.
Our cloud based system, we will continue to work towards this aim so we can be fully independent from the Hospital and be paper free.	Complete – We transferred all files in August 2021 and these were removed from TSH systems in March 2022.
Resuming support of the Hospital and patients in the new clinical model ensuring the patient voice is a priority.	Ongoing – We are now attending the Clinical model implementation short life working group.
Our online presence, we will continue to explore how we can be more active online.	Complete – We have a twitter page which we aim to continue to increase activity on (Handle: @PatientsAdvoca1) . We have also constructed and published a website (https://patientsadvocacyservice.scot/)
The ward drop-in, this will work in tandem with the clinical model to highlight how we can best support the patients.	Ongoing – We have amended the drop in for the ID service to weekly. Work on the drop in model for other wards will be addressed within the clinical model.
Our relationships with both internal and external colleagues.	Ongoing – We continue to liaise with external advocacy organisations through the SIAA. We started quarterly meetings

	with independent advocacy services in high security in England to share good practice.

6 Areas of Good Practice

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

- Review of Policies and Procedures
- Regular support sessions with all staff
- Ongoing staff growth, professional development and training
- Approachable, unbiased, and visible service
- Positive and professional relationships with stakeholders and other professionals relevant to patients and independent advocacy
- A variety of expertise within PAS team providing knowledge and experience in a unique setting
- Flexibility to adapt and meet the needs of TSH and patient group as required
- Annual feedback on the service from patients with patient involvement on the development of the Patient Questionnaire

7 Patient Stories

7.1 Staff Shortages

Lower staffing levels in TSH have presented challenges over the reporting period. Whilst TSH are aware of the issue, patients can become frustrated by being locked in their rooms for a period of time. Although TSH have offered information to patients on how they are trying to rectify this issue, for some this has not been enough. As per their right, patients have brought this issue to PAS for discussion. After listening to their frustrations and offering them their options, twelve patients in this period opted to submit a complaint. The purpose of highlighting this issue was not to have resolution but instead to air their frustrations at being further restricted through no fault of their own. As is their right, patients felt empowered to raise the issue through the hospital complaints system and have a response provided. Although it did not solve the issue, having their complaint upheld is a positive outcome for patients to know their concerns have been heard by TSH. For TSH, by offering patients access to independent advocacy, patients feel able to raise these concerns which they may not have done had they not had access to this service. It also allows TSH to take account of how patients are affected by being locked in their rooms, offer apology, to consider improved and more regular communications with patients on the status quo and remedial actions. It is also a positive outcome for PAS that patients feel comfortable to approach their advocate to discuss the problem and know their feelings will be highlighted. Again this shows positive working relationships between PAS and TSH and offers patients the chance to have their voices heard which the main aim of independent advocacy is.

7.2 Judicial Reviews

As per the Mental Health (Care and Treatment)(Scotland) Act 2003, all patients in TSH have the opportunity to challenge their detention under excessive security. Due to the lack of beds available in other services across the forensic estate, the majority of patients are supported to submit an excessive security appeal to secure their place on waiting lists. Over the reporting period, we have had a number of patients who having gone through the process and their order of excessive security has expired. At this time, patients can be frustrated they are still not moved on to lower levels of security. PAS are able to offer support to contact their solicitor to begin the process of a judicial review. This is a lengthy court process and PAS feels it necessary to offer reassurance and ensure patients understand the potential outcomes whilst also giving accurate information. This time can be very unsettling for patients as well as confusing given the legal discussions that take place. PAS is able to offer information in a user friendly manner whilst continuing to offer the opportunity to hear their concerns and take necessary actions to ensure proceedings are progressed as quickly as possible.

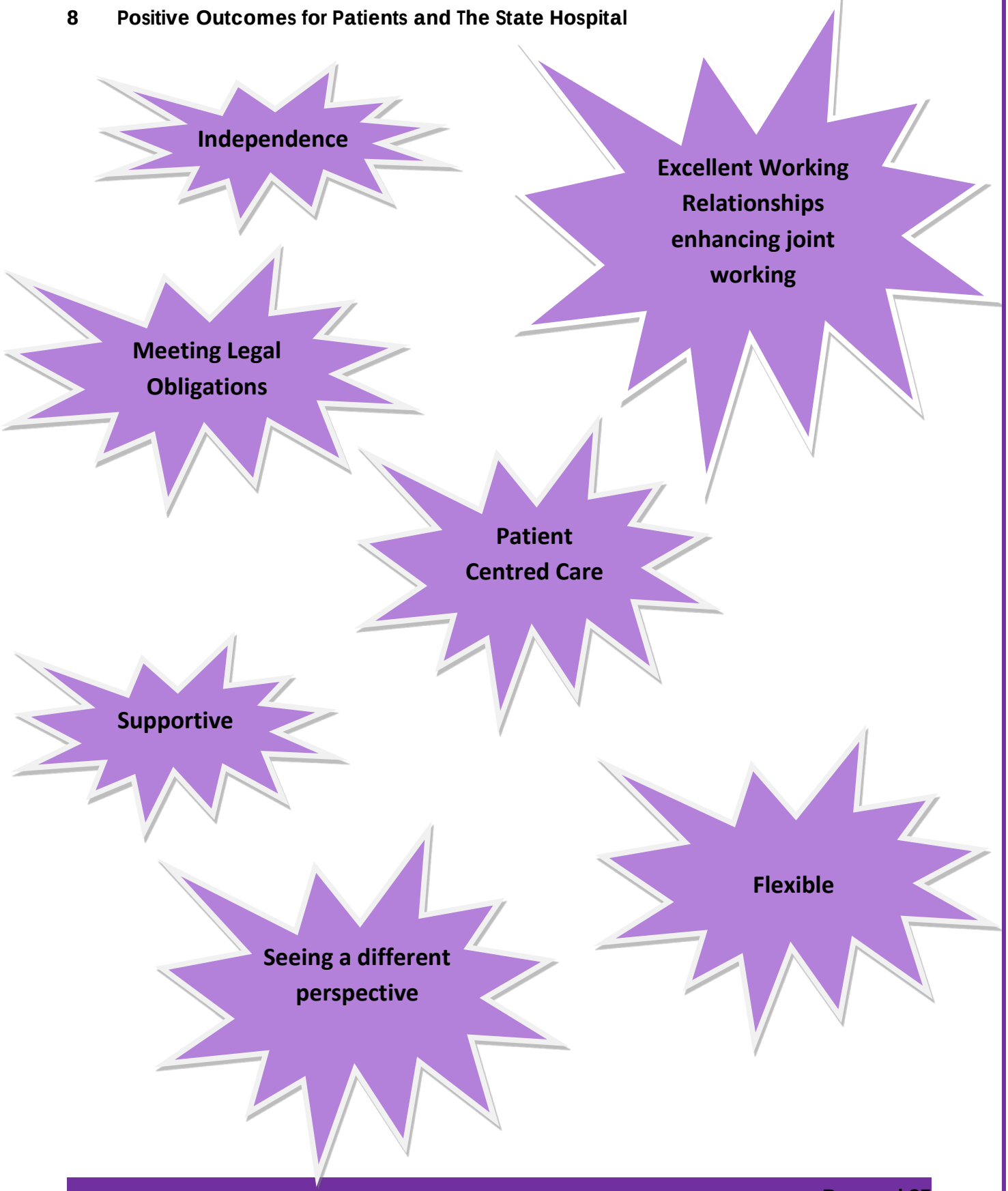
This is a beneficial outcome for patients as they have an independent service to discuss their concerns with, a service to gain accurate information on what action they are able to take and ensuring their rights are met. It also provides benefits for TSH by continuing to meet their legal duty to provide independent advocacy and ensure reassurance from both clinical teams and independent advocacy to help support patients to remain stable during a difficult time.

7.3 Impact to Patients from PAS Covid-19 Outbreak

This reporting period unfortunately saw the PAS team have a covid-19 outbreak for the first time since the beginning of the pandemic. Although we had taken precautions and had 2 bubbles in place with 2 separate teams, someone from each bubble unfortunately tested positive. In addition at this time, we also had someone who was not fully vaccinated to allow them access to TSH and an injury which saw an individual absent for a 2 week period. Our team were devastated to not be present in the hospital to offer independent advocacy to the patients. However, we continued to attend all case reviews and tribunals whilst working from home. TSH staff were vital for us communicating messages to patients whilst we were not on site. The PCIL was also imperative to offering support to PAS on actions we should take. The onsite office was not staffed for an 8 working day period however as noted, staff continued to work from home. During this time advocacy staff attended 7 CPA's via video conferencing and 4 mental health tribunals via teleconferencing highlighting that the PAS team continued to provide independent advocacy to patients and KPI's continued to be met. We were unable to offer the quick access to independent advocacy patients have been accustomed to however, as patients were informed we were not on site, they were very patient with the service and we were able to visit with them on our return.

This challenging time highlighted to PAS how necessary it was for us to have a plan in place for if there is a time where we are unable to be on site. By having the cloud system and access to TSH staff, we were able to continue to provide a service to patients. We are thankful this was the first time throughout the pandemic we were not on site and also grateful to our resilient staff being able to overcome the challenges during this period by continuing to attend meetings. Our thanks also has to go to the understanding of TSH staff and patients who were patient in our absence.

8 Positive Outcomes for Patients and The State Hospital



9 Feedback

"I'm happy to talk to advocacy as you're not part of the hospital and I have no one else to talk to" - Verbal

"That would be so much easier and should be something that's done across the board" Staff Verbal following a discussion on hospital procedures

"That's it sorted now, thanks for arranging that" – Staff Verbal following a repair reported to Estates

"Just to let you know, good news. I got the change of keyworker" - Verbal

"I'm not comfortable with her being in the room, I don't want to see her again" - Verbal

"I'd recommend speaking to advocacy because they're independent from the hospital and they can listen to you" - Verbal

"It's good you came to listen to me so I could get all that out" – Verbal

"Thanks for your time" - Verbal

Grateful for positive relationships with patients, the support we provide, particularly with the complaints process, and our general input - Complaints

Recognition for how we do really well at being connected to the hospital through the complaints process and with the PCT whilst also remaining independent – Nursing Director

"Thank you for sorting that for me" - Verbal

"Being able to maintain a critical service during this time is exceptional" – TSH Board

"Critically helpful in CPA meetings" – TSH Board


"I don't want to talk about it but thank you for giving me the option" - Verbal
"Much appreciated and thank you for doing all this so quickly" – Thank you card
"PAS continuing to attend case reviews has been really valued by the patients" – RMO
Thanks passed to all the team over the past year and enthusiasm expressed for continuing to work with us – Chief Executive
"What a great service you all provide" – Verbal
"Thank you for raising the question of rehab outings for me" - Verbal
"Thank you for your integrity and representing my views. I will miss you. The advocacy at Rowanbank will not be the same" – Verbal
"Thank you for being here at the tribunal for me, it would have been hard to have been sat myself" - Verbal
"Thanks for getting my property back from prison" - Verbal
"Thank you for your time listening to me" - Verbal
"Very helpful report that highlights the breadth of work advocacy does" – Verbal
"The Skye Centre Drop-In was much better for having relaxed conversations" - Verbal
"Thank [Advocate] for all she has done for my tribunal" - Phone
"Everyone's route to wellness goes through Advocacy" - Verbal
"I like that I can vent to you as it doesn't go anywhere else" - Verbal
"Thanks very much for phoning the solicitor for me, he's a really nice guy" - Verbal
"Thanks very much for being there at short notice. It's really good to know you'll be there" - Verbal
"Thank you to Advocacy for supporting the patient" - Verbal
"You make me feel better" - Phone


"That's what I like about you all, you're all caring" - Verbal
"As a team we are grateful for Advocacy's help trying to source a solicitor" - Email
"Everything is very good. Advocacy have always gone the extra mile for me. I really do feel you all couldn't do enough for me. You've always done everything asked for. I don't think the service can be bettered" - Verbal
"Thanks for all your help while I've been in the hospital" - Verbal
"Thanks for sending me down those forms" - Answermachine
"Thank you, it was appreciated you coming to my CPA" - Verbal
"Advocacy always do a stupendous job of helping to mediate with patients and stop things from escalating to a complaint" - Verbal
"Fab group of ladies, I always enjoy my chats" - Email
"You're doing your job brilliantly" - Verbal
"I'm glad there will be Advocacy present to represent him at the CPA" - Email
"Thanks for all your help while I've been in the hospital" – Verbal
"Thank you for being an ear" - Verbal
"Thank you, it was appreciated you coming to my CPA" - Verbal
"I have settled into medium secure fine – thank you for your support" - Verbal
"Thanks for all your work helping with my appeal and helping with my solicitor" - Verbal
"You managed to bring him back down, thanks for that" - Verbal
"Thank you for reading my tribunal statement" - Verbal
"Thank you for sorting out my solicitor" - Email

10 Future Areas of Work and Service Development

10.1 Organisational

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

- Continue to recruit Board Members to diversify our Board.
- Update our Patient Board Rep recruitment and training package.
- Recruit volunteers.
- Further expand our knowledge by maintaining current training and continuing to attend relevant courses and webinars.
- Organise the AGM with diversity in speakers.
- Continue to explore options to highlight the work of PAS in a wider scope.
- Continue to connect with other advocacy services and share best practice.
- Take note of publications such as the Scottish Mental Health Law Review and Forensic Mental Health Services: Independent Review and how these may impact PAS services.
- Continue to find ways to highlight our independence.

10.2 Service

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

- Restructure and streamline our reporting to better highlight the work we complete.
- Responding to consultations as appropriate, to champion the voice of our patients in their unique position.
- Complete the annual questionnaire and take forward the views of patients on the PAS service.
- Support TSH in regards to changes in the Clinical Model, ensuring patients' voices are prioritised.
- Review our ward drop in service and how this can better support our patients.
- Address issues regarding patients in seclusion or in very restricted positions.
- Join short life working groups to champion the patient voice.
- Further identify ways for patients to share ongoing feedback on the PAS service.
- Construct an admission booklet for new admissions to TSH detailing the role of advocacy and the support we can provide.
- Explore the options for having our own independent database.
- Continue to work towards independent email addresses.

11 Ethnicity Group Contacts for all Patients, 1st August 2021 – 31 July 2022

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

Ethnic Group	PAS Code	No. of Patients	Percentage	No. of Contacts	Percentage
White Scottish	1A	74	52.8%	912	55.2%
White Other	1B	9	6.4%	93	5.6%
White Irish	1C	*	0.71%	14	0.84%
White English	1D	*	2.14	19	1.15%
Other Ethnic Background	1E	*	0.71%	13	0.78%
White British	2A	41	29.2%	525	31.7%
Asian, Asian Scottish, Asian British	3B	*	0.71%	3	0.18%
African, African Scottish, African British	4B	*	1.62%	24	1.6%
Other Ethnic Groups, Chinese	3E	*	0.71%	13	0.78%
Unknown		7	5%	36	2.17%
	Total	140	100%	1652	100%

If the number of patients are below 5 a * is used to protect identity.

12 Financial Report

Income and Expenditure Report

For the period from 1 April 2021 to 31 March 2022

	£
Gross Income	147,014
Gross Expenditure	125,429
Incoming Resources	
Government Funding	146,853
Bank Interest	161
	147.014
Cost of Charitable Activities	
Employment Costs	119,853
Establishment Costs	1,583
Print, Post, Stationery	107
Subscriptions and donations	322
Training	110
Computer Costs	224
Trustees/Meeting Expenses	547
Sundries	31
	122,437
Governance Costs	
Accountancy Fees	1,644
Professional Fees	1,348
	2,992
Total Resources Expended as per Account	**125,429**
Cash & Bank Accounts	**67,010**
Liabilities payable in one Year	4,322
Net Current Assets	**62,688**

13 Next Review Date

The Patients' Advocacy Service Annual Report will be available to The State Hospital Board from August 2023.

14 Reference List

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

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

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

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

15 Appendix 1

48 patients filled in our questionnaire

What you told us…

Everyone who answered the question about what they think of advocacy said they thought it was between 'ok' and 'excellent'

Everyone who answered thought the advocates were friendly, approachable and reliable

41 people said the advocates take time to listen to them

Most people had used PAS and thought their problem had been solved.

What did people want us to change?

- Have an advocate regularly attend PPG
- Open the drop in

Most people knew who PAS were, what we do and that we are separate from the hospital

What are we going to do?

- Think about the Skye Centre drop in and how we can bring it back in some way
- We already attend the PPG each month, we will speak to the PCIT and see if we can come to more
- We want to make sure people know we are separate from the hospital, we need to think about how we can do that
- Update the advocacy poster in the ward

Paper No: 22/115

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 December 2022
Agenda Reference:	Item No: 13
Sponsoring Director:	Medical Director
Author(s):	Head of Planning and Performance Consultant Psychiatrist
Title of Report:	Clinical Model Implementation
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. This paper updates the Board on progress towards implementation.

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. At the Board meeting in June 2022, the Board approved Project Initiation Document which provided detailed plans for the implementation of the model. A project group has formed to take forward planning for the implementation of the new Clinical Model. The Board have received regular updates since implementation commenced, with the last update being at the October Board meeting.

3 ASSESSMENT

As the implementation phase of the project continues, project implementation activities and processes have included

- The Clinical Model Implementation Short Life Working Group continue to meet monthly
- The Project Plan is updated regularly and attached for information (Appendix 1).
- The Project Oversight Group have met monthly.
- Updating issues log and escalation of issues to the Project Oversight Board to support project management and effective decision-making.
- The Project Group meet weekly to progress project planning and management

Below is an update from progress achieved since the last report to the Board in October

- Clinical Guidance Groups have formed and have provided a draft of the clinical guidance for each of the clinical sub specialities.
- An overarching guidance document has been drafted to provide coherence across the pathway and ensure that there is consistency of approach in key processes.
- A contingency planning group have met to develop plans for addressing an excess of Major Mental Illness (MMI) patients should that position be realised following implementation of the model.
- Each department across TSH have developed plans for how they will operate within the new Clinical Model
- An implementation group have met to develop plans for the physical movement of patients.
- The Workforce Group have met and developed plans for some minimal initial staff movement required prior to patient moves. The group has also supported professional groups to consider how they allocate staff across the sub specialties.
- Discussions have taken place to describe and scope and responsibilities of the Hub and sub speciality leadership across the Hubs.
- The PPG have remained active in planning for the Clinical Model and have had discussions with key staff members to ensure patients perspectives and integral to plans.

To support staff communications, monthly update reports in the form of flash reports, summarising the month's activities and detailing the next steps, were issued in October and November (Appendix 2 and 3). These flash reports have been extensively shared and paper copies will be place within hospital reception to ensure whole workforce remains informed regarding progress of the Clinical Model. In addition, there is a specific intranet page which holds all Clinical Model information. A project team e-mail is available for staff to engage with the project. A Clinical Model session was held as part of the 'Seminar Series' to raise awareness and update staff

4 RECOMMENDATION

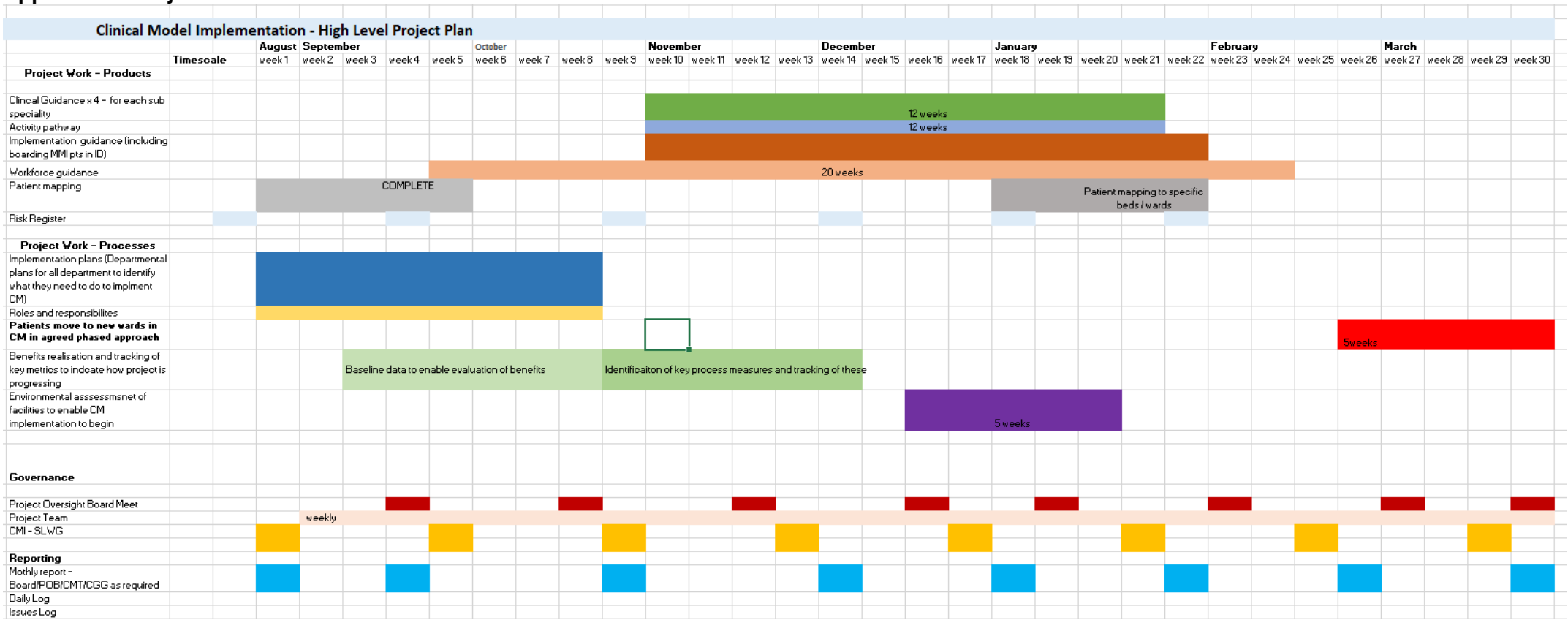
Board members are asked to:

- Note the contents of the attached documents.
- Discuss the implication of these for TSH.

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

Appendix 1: Project Plan



Appendix 2: October Flash Report

Clinical Model Flash Report – October 2022

Successful implementation is a shared responsibility.

Aim of Report:

The Clinical Model describes how clinical care is structured and delivered. As we move into the implementation stage for the new Clinical Model, we will provide a monthly report on work that has been delivered recently and describe the plan for the coming months. The aim is to have patient moves completed by the end of March 2023.

Clinical Model Activity in October 2022:

- Safety data was reviewed as concerns raised on level of clinical acuity and activity likely within the admission and assessment service. A paper was developed to provide analysis of data, assurance and further background information. This was discussed at the CMI – SLWG in October. This paper is available on the intranet page for CM
- Volunteers from professions were received to join the guidance groups for the four specialty areas.
- Intranet pages updated.

Overview of the New Clinical Model:

The Clinical Model had been developed to provide an enhanced treatment environment with a focus on recovery. There are four sub specialties within the model – Admission and Assessment, Treatment and Recovery, Transition and Intellectual Disability.

Planned Work in November 2022:

- Clinical Guidance Groups will be set up and first draft of guidance to be developed
- Scoping of the contents and timeframe for the security and environmental scan.
- Update issues log.
- Presentations at the Interregional Group and Clinical Governance Committee.

Planned Meetings – November 2022

Clinical Model Implementation SLWG:
22 November 22
Clinical Model Project Oversight Board:
21 November 22

Key Project Milestones:

To deliver the Clinical Model, the following Key Planning Elements require to be developed:

- Clinical Guidance.
- Workforce Guidance.
- Guidance for the physical movement of patients.
- Patient Mapping.
- Activity Pathway.

Communication and Engagement:

PPG have Clinical Model as a standing item and have started to consider what they need in preparation for the model.
All Heads of Service are encouraged to include the new model as a standing agenda item in their team meetings.
TSH Clinical Model intranet page can be accessed here.

Next Steps:

- Clinical Guidance groups will be created and a planned first draft will be brought back to the SLWG in November.
- The Implementation Guidance Group will be formed and have representation from relevant departments to plan the physical move of patients.
- Communication with key groups across TSH and stakeholders will take place to support ongoing awareness.

Contact Details:

- If you have any queries or concerns, please contact the Clinical Model Project Team on: TSH.ClinicalModelProjectTeam@nhs.scot

Appendix 3: November Flash Report

Clinical Model Flash Report – November 2022

Successful implementation is a shared responsibility.

Aim of Report:

The Clinical Model describes how clinical care is structured and delivered. As we move into the implementation stage for the new Clinical Model, we will provide a monthly report on work that has been delivered recently and describe the plan for the coming months. The aim is to have patient moves completed by the end of March 2023.

Clinical Model Activity in November 2022:

- The Clinical Guidance Groups were formed and met to discuss the draft specialty guidance. Updates were provided at the meeting in November and great progress has been made.
- The Implementation Group met to discuss the logistics of what is involved in a patient move and what are reasonable and realistic expectations timescales of moving patients and staff.
- A presentation was given to the Partnership Forum detailing progress to date and the background of decisions.

Overview of the New Clinical Model:

The Clinical Model had been developed to provide an enhanced treatment environment with a focus on recovery. There are four sub specialties within the model – Admission and Assessment, Treatment and Recovery, Transition and Intellectual Disability.

Planned Work in December 2022:

- Second draft of guidance to be presented at the SLWG.
- A Seminar Series to be held to facilitate a Frequently Asked Question (FAQ's) session.
- Further meetings to discuss contingency procedures for our MMI patients.
- Update issues log.

Planned Meetings – December 2022

Clinical Model Implementation SLWG:
20 December 22
Clinical Model Project Oversight Board:
21 December 22

Key Project Milestones:

To deliver the Clinical Model, the following Key Planning Elements require to be developed:

- Clinical Guidance.
- Workforce Guidance.
- Guidance for the physical movement of patients.
- Patient Mapping.
- Activity Pathway.

Communication and Engagement:

PPG have Clinical Model as a standing item and have started to consider what they need in preparation for the model.
Clinical Model Project Team will attend Partnership Forum monthly.
All Heads of Service are encouraged to include the new model as a standing agenda item in their team meetings.
TSH Clinical Model intranet page can be accessed here.

Next Steps:

- Continue to develop the specialty guidance and work across all groups to ensure cohesion.

Contact Details:

- If you have any queries or concerns, please contact the Clinical Model Project Team on: TSH.ClinicalModelProjectTeam@nhs.scot

Paper No. 22/116

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 December 2022
Agenda Reference:	Item No: 14
Sponsoring Director:	Medical Director
Author(s):	Head of Corporate Planning and Performance Head of Clinical Quality
Title of Report:	Quality Assurance and Quality Improvement
Purpose of Report:	For Noting

1 SITUATION

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

2 BACKGROUND

Quality Assurance and Improvement in TSH links to the Clinical Quality Strategy 2017 – 2020. TSH will work towards updating and revising the Clinical Quality Strategy in 2023. The current Clinical Quality Strategy sets out the direction, aims and ambitions for the continuous improvement of clinical care. It outlines the following 7 goals to ensure the organisation remains focussed on delivering our quality vision:

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

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

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

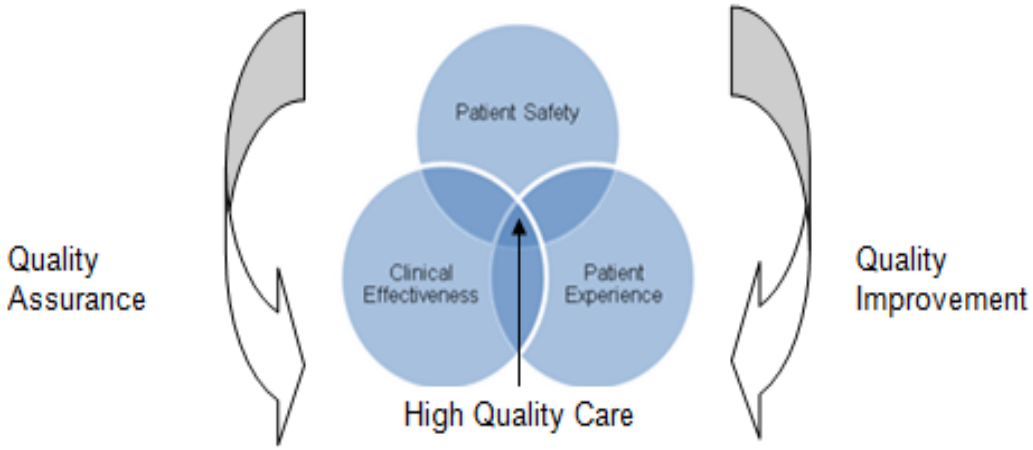
4) Gaining insight and assurance on the quality of our care

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

6) Evaluating and disseminating our results

7) Building improvement knowledge, skills and capacity

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



3 ASSESSMENT

The paper outlines key areas of activity in relation to:

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

4 RECOMMENDATION

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

MONITORING FORM

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

QUALITY ASSURANCE AND IMPROVEMENT IN TSH DECEMBER 2022

ASSURANCE OF QUALITY

Clinical Audit

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

The audit reports that have been approved since the last Board Meeting in October 2022 are:

- Compliance with "Consent to Treatment Form – Adherence to MWC Guidance" (T2/T3)
- Re-audit of the Care Programme Approach (CPA) documentation

Compliance with "Consent to Treatment Form – Adherence to MWC Guidance" (T2/T3)

Areas of good practice included

- On all occasions, the circle to indicate the type of treatment was shaded. This is an improvement from the last three years.
- In 96.1% of occasions, the patient consent form was completed within 7 days. This is similar to 2021.
- Using The British approved name for specific drugs improved from 96% (53) in 2021 to 98% (50) in 2022. There is a general trend of improvement in the last three years.
- Noting the administration route has improved from 93% (51) in 2021 to 96% (49) in 2022. There is a general trend of improvement in the last three years.
- Of the sixteen patients on Clozapine, all had this documented by name along with associated blood tests on the T2B. This is an improvement of 7% from 2021.
- In 2022, none of the T2Bs included IM PRN psychotropic medication. This is an improvement form 2021 and in line with the MWC guidance that any IM PRN psychotropic medication should be recorded on a T3B.

Areas for Improvement included

- On two occasions, the T2B had not been updated within the last three years. This is an increase from one occasion in 2021.
- Since the migration to the electronic prescribing system HEPMA, T2B forms have been stored in the treatment room folder as per the relevant policies. On two occasions, there was no copy of the latest T2B in the Medicine folder.
- On Three occasions, there was no expiry date completed in the T2B. This is an improvement from the last three years but not in line with MWC guidance.
- On seventeen occasions (33.3%), the broad class of the prescribed psychotropic medication was used and not the actual medication. This is an increase from 2021 and not in line with MWC guidance.
- The percentage of T2Bs where the dosage and frequency details were noted decreased from 95% in 2021 to 90% in 2022.

Re-audit of the Care Programme Approach (CPA) documentation

A spot check was carried out in September to ensure that the areas for improvement from the last audit were seeing improvements. As can be seen below, a number of areas for improvement have seen improvement since the last audit. The full report was considered by the Clinical Governance Group with an updated improvement plan agreed.

Priority level	Summary of action point	Evidence of improvement	Area for further improvement	Previous audit result	Current audit result
High	1. Complete & record the PANSS & the PANSS Interpretation sections within the Psychiatric Report section within the CPA document	Yes	Yes	53%	60%
High	2. Increase in the provision of Dietetic reports for annual reviews	Yes	No	94%	100%
High	3. Increase the number of Social Work recommendations being copied into the CPA document for annual reviews	Yes	Yes	35%	90%
High	4. Increased completion of the By When column of the Treatment Plan Objectives	No	Yes	28%	23%
High	5. Increase completion of the Additional Assessments Required of the Risk Management Plan	Remove from audit			
High	6. Increase completion of all sections under the Tailored Security heading	Yes	Yes	18%	60%
High	7. Increase completion of Levels of Security & Future Plans	No	Yes	94%	90%
High	8. Increase the completion of the Safeguarding Adults at Risk section of the Care Plan	Yes	No	82%	90%
High	9. What information should be recorded within the HCR-20 table - some use only the code for the risk item whilst others use the code and the full item title	Yes	No	71%	100%
High	10. What information should be recorded when noting a patient's diagnosis - the name or the name and code	No	Yes	77%	50%
High	11. Are the tick boxes beside the name of the documents included within the body of the CPA, Patient Views & Risk Management required	Remove from audit			
Med	12. Increased attention to detail is required prior to circulation of the final CPA document to ensure correct & accurate information is shared	Yes	Yes	Observation	
Low	13. Doctors in Training/RMO reports should be populated within the SHO/RMO Report to MDT section within RiO	Yes	Yes	35%	90%
Low	14. Increase completion levels for the Education/Awareness section of the Healthy Weight Management Plan (not in RiO)	No	Yes	71%	70%
Low	15. SHO/RMO Report template in RiO does not currently match the report required in the CPA document	No	Yes	See Action Point 13	
Low	16. Given the use/omission of different headings within the Admission History section, should there be uniformed sub - headings	Yes	Yes	22 alternative headings	14 alternative headings
Low	17. Scenario Planning for Child Protection section is completed well within the CPA	Yes	Yes	94%	80%

	document, it is poorly completed within the dedicated area within RiO				

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

- CPA/MAPPA 12 monthly report
- Child and Adult Protection 12 monthly report
- Rehabilitation Therapies 12 monthly report
- Physical Health Steering Group 12 monthly report
- Person Centred Improvement Service 12 monthly report
- Workforce Governance report
- Learning from Feedback report
- Learning from Complaints report
- Incident Reporting and Patient Restrictions report
- Patient movement report
- Corporate Risk Register - clinical
- Covid 19 Update
- Discussion Item – Clinical Model

One of the main improvements to both the Incident Reporting and Workforce Governance reports is the ward closure data that can now come straight from Datix:

In Q1 the process for recording Staffing Resource Incidents on Datix was modified to record Full Closures (Ward closed for duration of shift), Partial Closure (Ward closed for a period of time during shift) and Modified Working (Ward remains open but modifications have been implemented to allow for patients day to operate).

Table 1: Staff Resource Quarterly Data

	Annual			Quarterly			
Incident Category	**2019/20**	**2020/21**	**2021/22**	**2021/22 Q3**	**2021/22 Q4**	**2022/23 Q1**	**2022/23 Q2**
Full Closure	**-**	**-**	**-**	**-**	**-**	**21**	**72**
Partial Closure	**-**	**-**	**-**	**-**	**-**	**15**	**138**
Modified Working	**-**	**-**	**-**	**-**	**-**	**218**	**735**
Other	**213**	**110**	**838**	**252**	**284**	**204**	**43**
Total	**213**	**110**	**838**	**252**	**284**	**458**	**988**

Increase in numbers of Staffing Resource Incidents is partly due to a push in recording these types of incidents. Communications were sent to staff to ensure that an incident was recorded for each shift that was impacted by deficits. This is to allow Risk and Resilience to gather accurate data for each wards and will provider richer data to analyse. Data should begin to level off from Q3 onwards and give a full picture of the staffing resource situation in TSH.

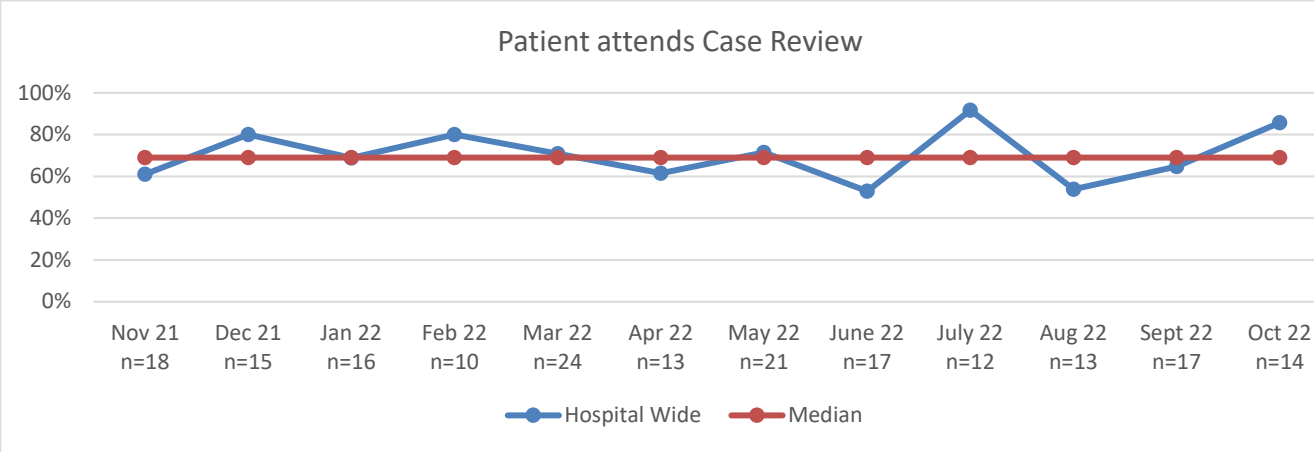
Variance Analysis Tool – Flash Reports

Flash reports were introduced in October 2022 to provide a very quick overview of the areas within the VATs that are either improving, or require some attention. The October report is below for information.

Data showing improvement from last report

Overall VAT Completion was 99%

Nursing - Completion of Nursing VAT interventions was 100% with continued good results for the majority of most interventions.
Patient attendance at the Case Review increased from 65% to 86%



Medical – Completion of the Medical VAT interventions was 100% with no areas of concern.

Dietetics – Completion of the Dietetic VAT interventions was 100% with no area of concern.

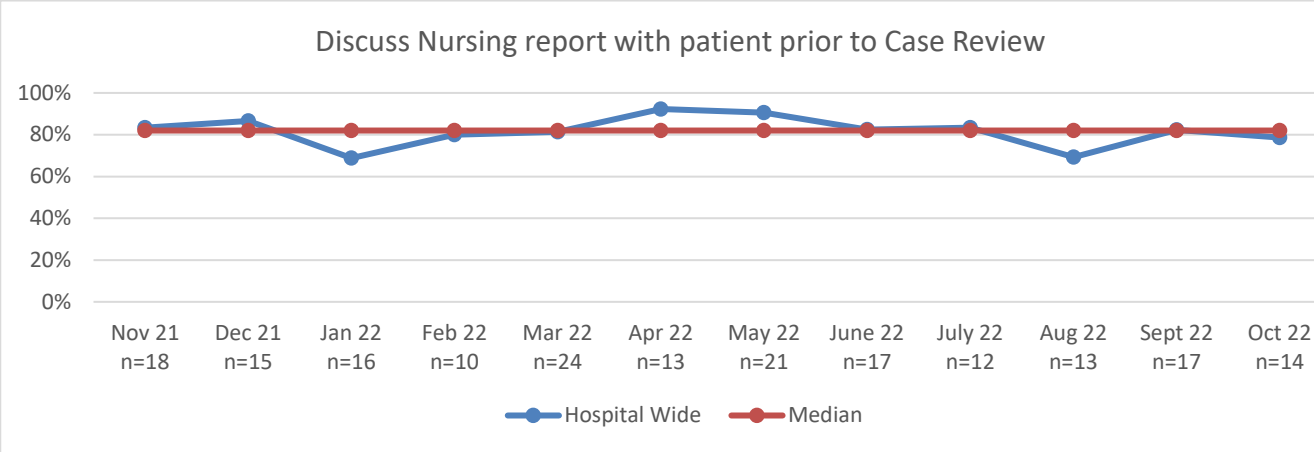
Pharmacy – Completion of the Pharmacy VAT interventions was 100% with good results for report provision (100%) and attendance.

Security – Provision of the report also at 100%

Social Work – Completion of Social Work VAT interventions was 100% with no areas on concern.

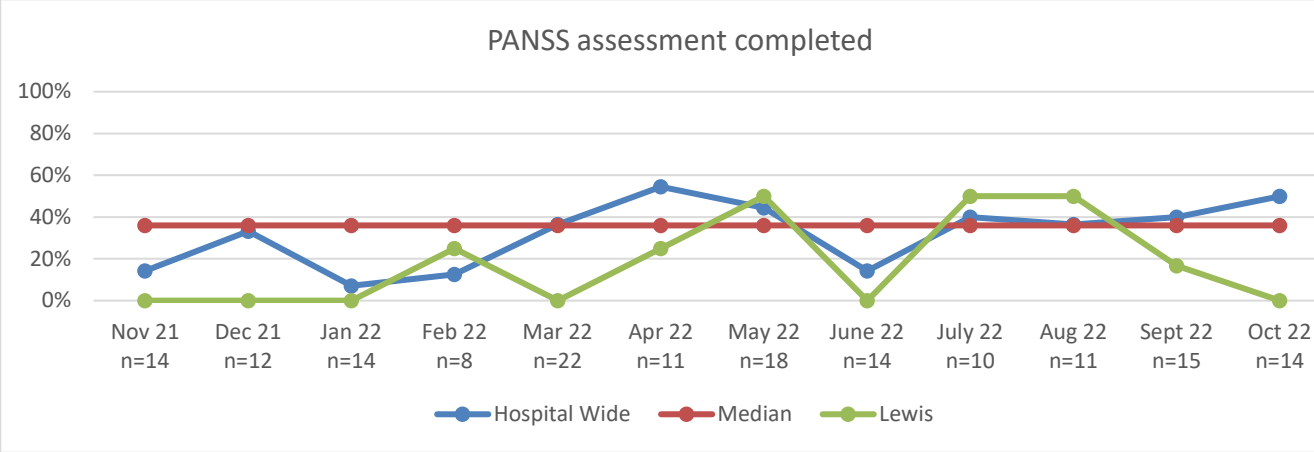
Data showing concern from last report

Nursing - There continues to be issues around evidence of nursing discussing the nursing report with the patient prior to the review



In Oct 22, a new VAT was circulated to collect more detailed reasons around nursing attendance at the case review. Key Worker attendance (28.5%), AW (28.5%) and Nursing rep (42.9%) – detailed reports have been highlighted in the individual hub Nursing flash reports.

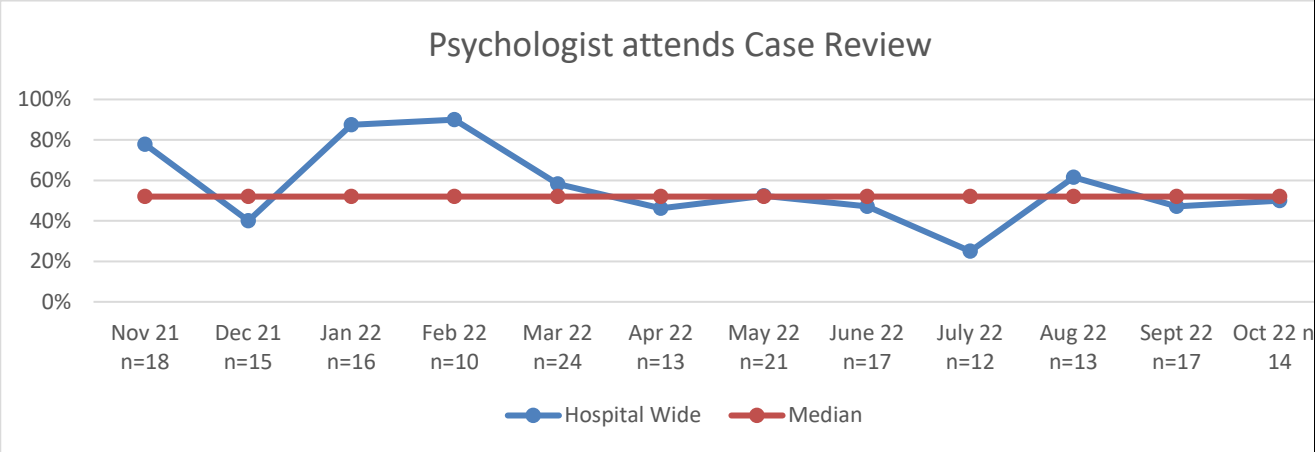
Medical - The graph below that shows although overall there was improvement in the PANSS being carried out there were no PANSS carried out on Lewis – the reasons for this were that the patients were unable to tolerate the assessment.



Occupational Therapy – Although completion of the OT VAT interventions was excellent at 100% results continued to be affected by staff vacancies and sickness.

Pharmacy - both provision of the MaPPs summary and medication discussion with the patient were at zero in October 22. On 1 occasion on Arran this was due to the patient's presentation and in the other 5 cases this was due to workload pressure.

Psychology - attendance was below the 100% target. On 7 occasions, the Clinical Psychologist attended the patient's review, on 1 occasion the Assistant Psychologist attended and on 6 occasions the Advanced Nurse Practitioner attended – this brought overall psychology attendance up to 71%. Please note however that there are still vacancies in the Psychology Dept., which is affecting this.



Skye Activity Centre – completion was 100% but results for a SAC representative discussing the report with the patient prior to the review were affected by staffing issues – decreasing from 100% in Sept 22 to 40% in Oct 22.

Any challenges with the systems that are being addressed

Nursing - Suggest the introduction of a new sub-head on nursing RiO progress notes - Nursing CPA Report discussion. This is the nursing intervention that is most often not completed.

Psychology - ensure that all interventions are completed of the VAT data collection sheets in order to identify who from Psychology is currently working with the patient and where there is no Psychology input due to vacancies.

Please highlight any support required

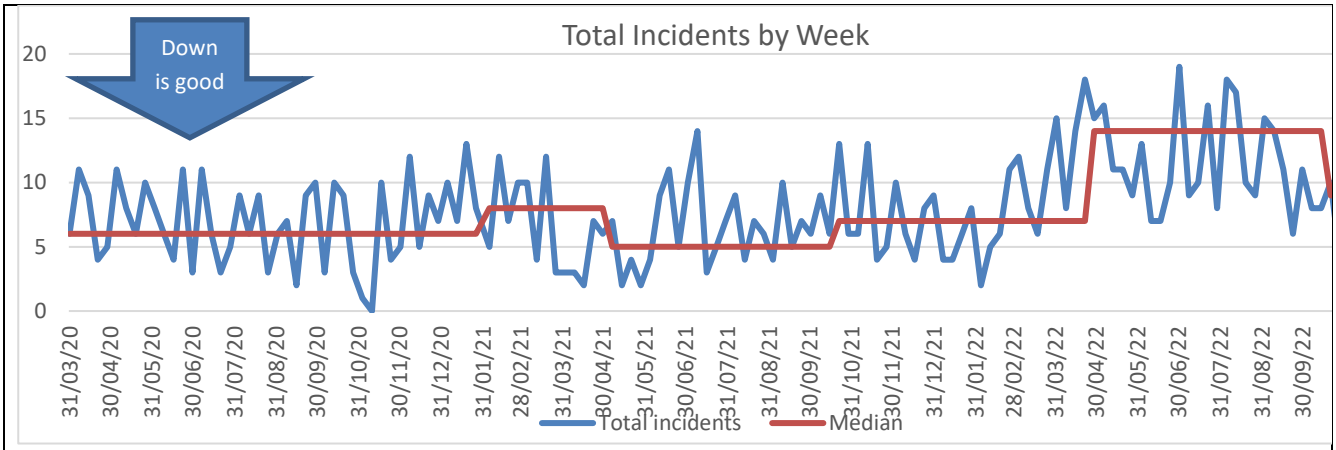
Support from **Medical** and **Psychology** colleagues to ensure that all data is provided on the 1st on the month.
Security - Support from Clinical Security Liaison Manager to complete their VAT data prior to commencing annual leave.

Clinical Quality Flash Reports to Activity Oversight Group

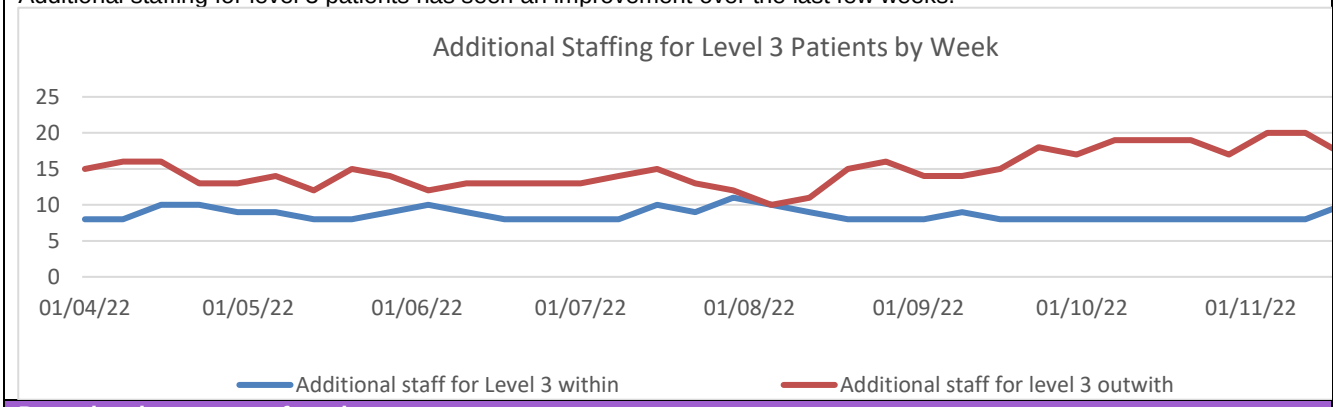
The Activity Oversight Group took over the role of monitoring the activity data earlier this year. Clinical Quality now produce a flash report for each meeting that highlights areas of improvement, concern and any system issues. The most recent report is below and will be discussed in full at the Activity Oversight group:

Data showing improvement from last report

The incident data has remained low in the last month with random variation.



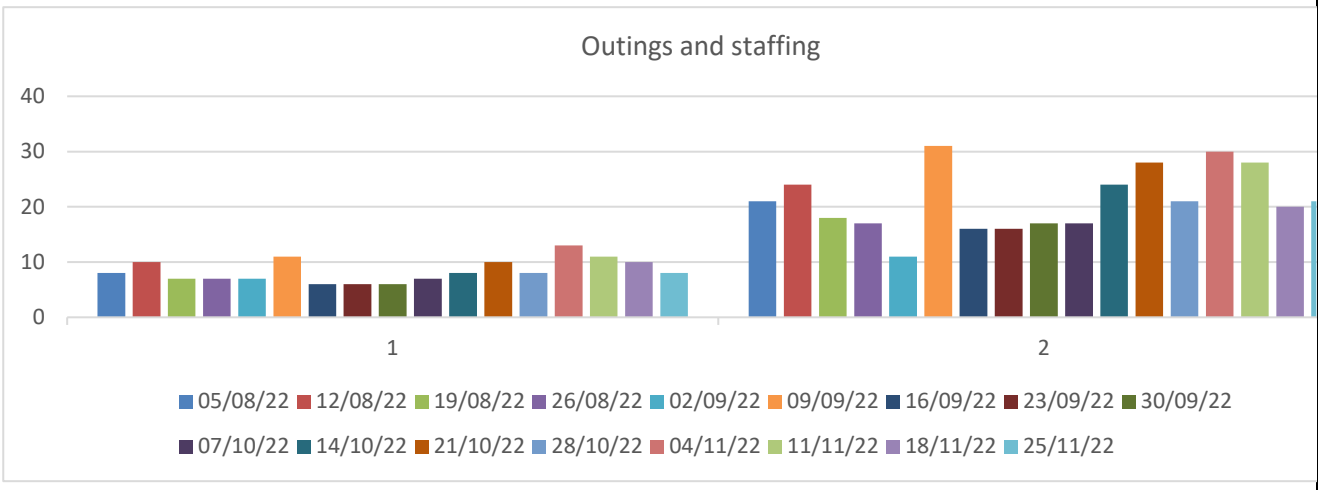
Additional staffing for level 3 patients has seen an improvement over the last few weeks.



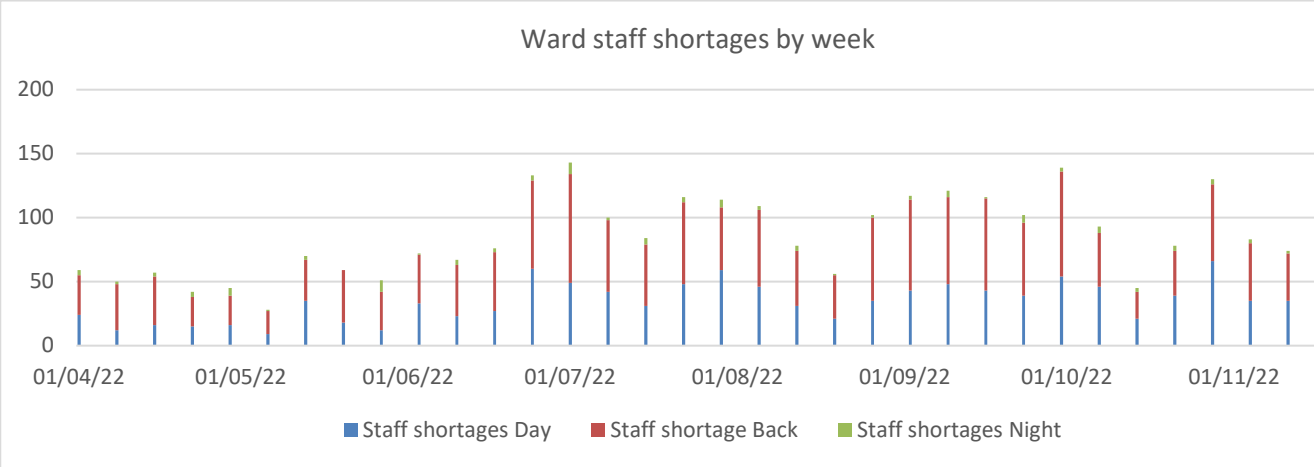
Data showing concern from last report

There are a couple of run charts that are still showing concern over the last month that may be impacting on the activities that can be provided to patients:

We are still seeing a large number of staff required for outings that will impact on the staff available ion the ward. This data **does not** include the patient requiring inpatient care in a general hospital with 3 staff present at all times. This patient has been boarding out since mid-September.



In recent weeks, we have seen ongoing issues with staff shortages



We are also seeing larger increases from this time last year in the number of patients not accessing fresh air or physical activity. Along with this, the total number of timetable activities provided (both planned and drop-in have decreased over the last 4 weeks (bad weather and system failures may have impacted on this data).

We have seen very few complaints over the last month, which may be concerning considering the impact of ward closures on our patients.

Areas with sustained levels

n/a

What areas have been worked on in relation to systems in the last month

Further communication re the RiO patient dashboards will be provided and sent round the wards. Unfortunately a large number of staff are not using these dashboards that would save them a lot of time when preparing their weekly reports.

The Hub Leadership Team dashboards have been approved at Clinical Governance Group. These include run charts for the majority of the data that Clinical Quality currently collect daily. This should make the data more easily accessible to Clinical Team staff and Clinical Quality. It is hoped that these will go live mid-December.

No further communication re the changes that would require to be made to the timetable to allow the physical activity forms to be archived. Clinical Quality will await direction from AOG on this, but it has to be recognised that clinical staff are still duplicating their efforts until this piece of work is completed.

Any challenges with the systems that are being addressed

n/a

Please highlight any support required

Looking for an update on the discussions re the items not currently on the timetable to allow us to archive the physical activity forms.

QUALITY IMPROVEMENT

QI Forum

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

QI Capacity Building
Planning is underway locally for QI essential training, however this has been impacted by staffing challenges across TSH. TSH has also been allocated and filled 3 places in the future cohort 43 of ScIL commencing in early 2023, preparation underway for planning projects for each participant. Applications are currently open for the Scottish Coaching and Leading for Improvement Programme (SCLIP), TSH have been allocated 1 place on this training course. Early planning is underway to offer another round of TSH3030. Aim of this would be to support new teams in QI activity following the implementation of the Clinical Model.

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

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

Quality and Safety
Four Quality and Safety (Q&S) Visits was held within Mull 1, Lewis 3, Iona 3 and the Skye Centre over this period. Patients and staff have engaged well in these visits and themes have emerged around time for staff to access staff support resources. Areas for improvement were noted and these will be discussed at our local Patient Safety Group for further comments and action if required.

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

Over a 12-month period, an average of 200 evidenced based guidance documents issued from a variety of recognised bodies can be reviewed for relevancy by the Clinical Quality Facilitator. During the period 1 October to 30 November 2022, 36 guidance documents have been reviewed. There were 26 documents which were considered to be either not relevant to TSH or were overridden by Scottish guidance and 9 documents which were recorded for information and awareness purposes. One document from SIGN regarding the pharmacological management of migraine is currently under review.

Table 2: Evidence of Reviews

Body	Total No of documents reviewed	Documents for information	Evaluation Matrix required
Mental Welfare Commission (MWC)	6	6	0
SIGN	1	0	1
Healthcare Improvement Scotland (HIS)	2	2	0
National Institute for Health & Care Excellence (NICE)	27	1	0

As at the date of this report, there are currently an additional 6 Evaluation matrices nearing the end of the review process. It should be highlighted that the completion of the review process had been paused due to the implementation of operational restrictions as a result of staffing issues. Please see the table below for further information.

Table 3: Evaluation Matrix Current Situation

Body	Title	Allocated Steering Group	Current Situation	Publication Date
MWC	Social Circumstances Reports (SCR) – Good practice guidance on the preparation of SCRs for MHOs and managers	CGG	Following discussion at CGG on 30/11/2022, a question was raised regarding the decision made on 1 recommendation. This has been flagged up to the Social Work Team Leader and is currently pending feedback prior to being completed	April 2022
NICE	Stroke & transient ischaemic attack in over 16s: diagnosis & initial management	PHSG	Only 3 from 70 recommendations relevant to TSH. TSH would comply with these however can only provide evidence for 1 given lack of occurring events. Tabled for next PHSG (not met since Oct 2022) for the group to agree that a full gap analysis is not required in this instance	April 2022
NICE	Gout: Diagnosis & management	PHSG	Gap analysis has been completed and is tabled for next PHSG (not met since Oct 2022) for agreement and sign off. 100% compliance achieved	June 2022
NICE	Multiple sclerosis in adults: Management UPDATED	PHSG	Previously reviewed in October 2014 where document was recorded as being for information purposes only. At that point TSH had no patients with an MS diagnosis & PHSG agreed that should this change, the guideline would be used. Current 2022 situation is same however ongoing discussions regarding 1 patient's possible diagnosis. Review being conducted by Practice Nurse and GP	June 2022
NICE	Pneumonia in adults: diagnosis & management	PHSG	Gap analysis currently being completed by GP and Practice Nurse	July 2022
NICE	Self Harm: Assessment, management and preventing recurrence	MHPSG	Gap analysis required. Availability requested from MHPSG members in order to schedule review meeting	September 2022

There are currently 5 additional evaluation matrices which have been outstanding for a prolonged period of time and await review by their allocated Steering Group. The progress of the first 2 evaluations from HIS and the MWC was temporarily paused due to TSH adapting to the COVID-19 pandemic however as per Gold Command, action on matrix completion began again at the start of July 2020. The responsibility to review these matrices changed ownership from the PMVA Review Group to the Patient Safety Group which recommenced meetings in September 2020. Work is progressing with both with an anticipated completion date of early 2023. 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. There are 2 remaining documents from NICE which are currently undergoing the review process regarding Chronic Kidney Disease and Rehabilitation after Traumatic Injury – it should be noted that these are fairly comprehensive documents and as such, a reviewed review process is being followed in order to reduce the time required by all involved MDT members. The CKD Evaluation Matrix has been completed and will be tabled at the next PHSG for final review whilst work is progressing to complete the Evaluation Matrix regarding the Rehabilitation document.

Table 4: Evaluation Matrix Summary

Body	Title	Allocated Steering Group	Current Situation	Publication Date
HIS	From Observation to Intervention: A proactive, responsive and personalised care and treatment framework for acutely unwell people in mental health care	MHPSG (via Patient Safety)	Evaluation matrix completed with 28 outstanding recommendations Patient Safety meeting took place mid-September. Evaluation matrix to be revisited upon creation of updated draft Clinical Engagement Policy.	January 2019
MWC	The use of seclusion	MHPSG (via Patient Safety)	Work ongoing. Release of updated Seclusion Policy currently on hold due to ongoing work with Clinical Engagement Policy currently being drafted with seclusion tier 1 and 2 being incorporated. Both to be launched together.	October 2019
PH England	Managing a healthy weight in adult secure services - Practice guidance	SHC	Unable to be completed within the tight deadline set by the Supporting Healthy Choices group due to poor attendance at the review meeting and delay in members submitting feedback responses. Awaiting next SHC meeting in order to take document forward.	February 2021
NICE	Chronic Kidney Disease: Assessment and management UPDATED	PHSG	Initial review delayed due to Practice Nurse vacancy and extended leave by the GP. Review decision made and Evaluation Matrix to be completed. Resulting delays on prioritising of Practice Nurse duties. Due to large number of recommendations, review process will be split into 2 parts: Part 1 will be reviewed by GP/Practice Nurse and Part 2 will be wider multi-disciplinary review. Evaluation Matrix now completed with 100% compliance achieved. Is tabled for next PHSG (not met since Oct 2022) for agreement and sign off.	Aug 2021
NICE	Rehabilitation from Traumatic Injury	PHSG	After initially being thought of as not relevant to TSH setting, decision was changed and gap analysis is to be completed. Due to large number of recommendations, review process will be split into 2 parts: Part 1 will be reviewed by AHP/Manual Handling Advisor and Part 2 will be wider multi-disciplinary review. Part 1 Evaluation Matrix review commenced June 2022 with 3 review meetings conducted. Part 2 will commence during December 2022	January 2022

THE STATE HOSPITALS BOARD FOR SCOTLAND

Clinical Governance Committee

Minutes of the meeting of the Clinical Governance Committee held on Thursday 11 August 2022.

This meeting was conducted virtually by way of MS Teams, and commenced at 09.45am.

Chair:	
Non-Executive Director	Cathy Fallon
Present:	
Non-Executive Director	Stuart Currie
Vice Board Chair	David McConnell
In attendance:	
Risk Management Facilitator	Stewart Dick [Item 6]
Person Centred Improvement Lead	Sandie Dickson [Item 8]
Consultant Forensic Psychiatrist	Sheila Howitt [Item 15]
Chief Executive	Gary Jenkins
Head of Planning and Performance	Monica Merson
Board Chair	Brian Moore
Director of Nursing and Operations	Karen McCaffrey
Head of Corporate Governance	Margaret Smith
Head of Clinical Quality	Sheila Smith
Medical Director	Lindsay Thomson
Personal Assistant	Julie Warren [Minutes]

1 APOLOGIES AND INTRODUCTORY REMARKS

Mrs Fallon welcomed everyone to the meeting, and apologies were noted from Dr Khuram Khan (Consultant Forensic Psychiatrist and Chair of the Medical Advisory Committee) who was unable to attend this meeting.

2 CONFLICTS OF INTEREST

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

3 TO APPROVE THE MINUTES / ACTON NOTE OF PREVIOUS MEETING HELD ON 12 MAY 2022

The Minutes of the previous meeting held on 12 May 2022 were noted to be an accurate record of the meeting following minor amendments.

Action: Julie Warren / Margaret Smith

The Committee:

1. Approved the minute of the meeting held on 12 May 2022 following minor amendment.

4 PROGRESS ON ACTION NOTES

The Committee received the action list and noted progress on the action points from the last meeting.

Professor Thomson advised that a review had been undertaken of the Service Level Agreement in relation to Pharmacy with Key Performance Indicators so that better indicators could be added to reporting in the future. The Committee was content to regard this action as closed.

The remainder of actions were completed or on today's agenda for discussion.

The Committee:

1. Noted the updated action list.

5 MATTERS ARISING

There were no additional urgent matters which arose for discussion.

6 DUTY OF CANDOUR ANNUAL REPORT 2021/22

Members received and noted the Duty of Candour (DOC) Annual Report 2021/22, by Mr Dick, Risk Management Facilitator, who provided a brief overview of the paper which detailed how the organisation operated the Duty of Candour during the period 1 April 2020 to 31 March 2021.

Given the decrease in training figures of Duty of Candour LearnPro e-learning, with the percentage uptake of 97% for 2020/21 to %92.2% for 2021/22, Mr Dick advised that that it was an action of the DOC group to ensure these figures were improved in this area.

Also of note was the increase in incidents the Risk and Resilience Department forwarded to the DOC Group for consideration i.e. 103 incidents, an increase of 63 in the previous year. Only one case met the criteria for Duty of Candour, At the time of writing the report, this incident had been still under investigation. Mr Dick advised that this investigation was now completed and that the report would be shared with the relevant persons with any required learning implemented. This would be included in future reporting to the Committee.

In relation to Duty of Candour Learnpro e-Learning Training table, Mr McConnell requested more background information in terms of compliance, and the breakdown between registered and non-registered staff, Mr Dick advised that the table showed the number of staff who completed the electronic learning module only. There had been a drop off in non-clinical staff completing this, and this would be a focus for the DOC Group to ensure progress was made in this area. There was discussion on this point and Professor Thomson advised that it was likely due to turnover in staff. She added that Duty of Candour was a well-functioning system within the hospital, with incidents being reviewed thoroughly. It had a very high threshold of criteria and only two cases to date had met these criteria.

Mr Dick was asked to provide an update in respect of the investigation now concluded, and also to add a table to the report which categories the incidents reported to the DOC Group. An error in this report was also noted i.e. the number of incidents reported in 2019/20 had been one making two in total.

Action: Stewart Dick

The Committee:

1. Approved the Duty of Candour Annual Report 2021-22 as an accurate account, subject to one minor amendment and felt reassured by the content of the report.

2. Requested changes to reporting as detailed.

7 CORPORATE RISK REGISTER

Members received and noted the Corporate Risk Register update which was presented by Mr Dick. He provided updates on the main points from the report which included updates on ND17 being at target level and ND70 at high risk, with all risks overall, in date. He emphasised that risks were being actively reviewed with the relevant risk owners.

Mr McConnell queried whether the wording was correct around the narrative for ND73 and HRD112 to say were increasing, which was not reflected within the table of target grading. Mr Dick advised the text was indeed correct and these had decreased and the table would be updated to reflect this. The updated Corporate Risk Register would be submitted to the Board at its meeting on 25 August 2022.

Action: Stewart Dick

The Committee:

1. Noted the reviewed the current Corporate Risk Register.

2. Accepted it as an accurate record following amendment as agreed above.

3. Agreed that no additional information was required for future reporting.

8 LEARNING FROM FEEDBACK REPORT

Members received and noted the Learning from Feedback Quarterly Report (Q1) which provided the Committee with an overview of activity related to feedback for the first quarter of the financial year 2022/23 (1 April to 30 June 2022). Mrs Dickson, Person Centred Improvement Lead provided members with a brief summary of the report and highlighted the following areas in terms of feedback shared related to concerns and a number of themes identified;

- staff attitude
- impact of caring for Intellectual Disability patients in other wards
- not being involved in making choices relating to prioritising activity
- Compliments were shared about quality of care, recognition of the value of Family Therapy, visiting and baking produced by the Hospital's Catering Department.

Mrs Dickson advised that work was underway to further explore feedback from patients around staff attitude. Further, the feedback from patients regarding prioritisation to open the Sports Department, over other departments such as crafts, to recognise patient preferences, which may be different. She further advised that despite challenges relating to the impact of Covid-19, the national 'What Matters to You?' initiative was facilitated this year with a good level of patient engagement.

Mr Moore highlighted feedback similar to that noted in point two around some groups of patients having to return to bedroom areas following evening meals. Mr Moore advised this was also mentioned following a recent Quality and Safety walkround which enhanced the benefit of these in terms of awareness of patient concerns. Mrs Dickson advised that a new system to capture data around the amount of time patients spend in their bedrooms was being developed and was at the pilot stage. Mr Moore welcomed this piece of work and the importance of maintaining this new arrangement following the pilot period.

Members noted that the Person Centred Improvement Team continued to engage with the independent Patients Advocacy Service (PAS) and Complaints and Legal Claims Officer in order to triangulate information shared by patients. Mr Gary Jenkins further added that himself and Director of Nursing and Operations were meeting with the PAS on a two monthly basis to obtain and discuss feedback from the patient perspective.

Mr Currie emphasized the importance of returning to activity based model and the various options and range of activity available to aid to the decrease in time patients spend in bedrooms.

The Chair welcomed the update on effective relationships and the requirement to remain sighted on the monitoring work on this theme. Mrs Fallon also expressed that she looked forward to viewing the outcome plans from the 'What Matters to You?' initiative.

The Committee:

1. Noted the Learning from Feedback Report, pertained to Quarter One, and its relevance, in terms of ensuring that patient and or carer experience informed service delivery.

9 LEARNING FROM COMPLAINTS REPORT

Members received and noted the Learning from Complaints report, presented by Ms Margaret Smith. The report provided an overview of activity of complaints, concerns and enquiries for the first quarter of the financial year 2022/23. The report also detailed the complaints received, the stages at which they were handled, as well complaints closed within this time period. Ms Smith provided a high level account of the content of the report and provided assurance on two key areas, (1) the hospital's positive performance in supporting resolution of complaints in a timely way, and (2) work ongoing with the Patients Advocacy Service and Complaints and Legal Claims Officer to reassure patients to come forward and raise complaints without fear of impacting on relationships with staff

Members acknowledged that this data enabled the organisation to develop and improve service delivery by taking account of stakeholder feedback which would also support focus on any potential for organisational learning.

Mr Currie welcomed the report and commended staff for their efforts in resolving complaints in a timeous manner, particularly when services were under pressure due to the impacts of Covid-19. He noted the openness of the organisation (reflected in the number of complaints upheld) which would build confidence in the system from a staff and patient perspective. Professor Lindsay Thomson added that research on complaints was carried out previously with Police and SPSO colleagues with time taken to deal with complaints being a major factor, so this performance was positive.

The Chair commended Ms Smith and Complaints and Legal Claims Officer on their high level detailed report and also reflected on the openness of the organisation in the way it handled complaints meaning that a rise in complaints received was not necessarily negative.

The Committee:

1. Noted the Learning from Complaints Report, pertained to Quarter One.

10 MENTAL HEALTH PRACTICE STEERING GROUP 12 MONTHLY REPORT

Members received and noted the report on activities of the Mental Health Practice Steering Group (MHPSG), which Professor Lindsay Thomson provided an overview of, noting that the group now had two new chairs, who would in future provide reporting to the Committee. She also noted the contribution made by the Clinical Quality department in this reporting.

Members reviewed and acknowledged that alongside its formal quality assurance role in monitoring Grounds Access and Advanced Statements, the MHPSG would also hope to engage in the following areas;

- Develop and test ways to increase the utility of clinical outcome measures for frontline staff
- Review and propose changes to the Care Programme Approach process
- Support the Realistic Medicine Action Plan as required
- Support the development of the implementation plan for the new Clinical Care Model
- Establish the viability of a Structured Clinical Care Model at The State Hospital

- Continue to develop Trauma Informed Care at The State Hospital
- Develop potential Family Interventions

In answer to a question from Ms Fallon, Professor Thomson clarified that DRAMs was the risk assessment used within the Intellectual Disability Service.

The Committee:

1. Approved the activities and areas of work the Mental Health Practice Steering Group intended to focus on over the following year and acknowledged the assurance of the Action Plan system in place to monitor progress.

11 SCOTTISH PATIENT SAFETY PROGRAMME 12 MONTH REPORT

Members received and noted the report from the Director of Nursing and Operations, which provided the update on the core activities under the four key safety principles i.e. communication, leadership and culture, least restrictive practice, and physical health, alongside updates on Key Performance Indicators, Quality Assurance and Improvement activities, and any challenges faced, related to the period July 2021 to June 2022.

Mrs McCaffrey provided members with a brief overview of the report and advised of the planned activity for the Patient Safety Group (PSG) over the following twelve-month period. She advised that the local suite of SPS Key Performance Indicators would be reviewed at every PSG meeting and that the revised safety principles headings would be incorporated in to future Annual Reports to the Committee. She advised that the four key workstreams were working well and the Project Manager post was successfully fulfilled and working well, therefore was extended for a further twelve-month period.

In terms of leadership and culture, Mrs McCaffrey advised that a total of three quality and safety walkrounds were achieved from their commencement in February 2022. Two visits were cancelled due to Covid-19 transmission within ward areas and a further two were cancelled due to staffing pressures experienced across the site, all four were noted to be in the progress of being rescheduled at this time.

Mrs McCaffrey advised that the new clinical observation and engagement policy had been created and shared at a number of forums and committees across the hospital and was positively received. The revised timeline for implementation was set for January 2023 with stakeholder engagement scheduled for the Autumn of 2022.

In relation to quality assurance activity, Mr Currie highlighted that violence and aggression number of incidents were low regards to specific hubs areas and queried if further context of these numbers would be provided in future reports to provide further understanding of the lower and higher peaks. Mrs McCaffrey advised that further analysis in this regard would be provided to understand the importance in changes in peaks. In order to enhance the narrative going forward, core groups would be descried rather than specific patient numbers. Mr Currie took the opportunity to highlight and note the positive decrease in the number of incidents during 2020 – 2021.

Mr David McConnell, reiterated the benefit in contextualising the data, as well as supporting audit findings and taking action and a balance of these findings, alongside areas of good practice and areas of improvement. The scope for a detailed contextual summary was welcomed in future reports. Mrs McCaffrey reassured the Committee, this would be a focus of the Patient Safety Group.

Action: Karen McCaffrey

Professor Lindsay Thomson reminded the Committee that quarterly reporting on incidents and assaults were reviewed by the Committee.

Mr Moore, advised that following his participation in recent quality and safety walkrounds, feedback from nursing staff around shift patterns was highlighted and potential issues around the handover periods. Mr Moore suggested it beneficial to receive any potential data collectively from these walkrounds. Mrs McCaffrey advised that the Patient Safety Group would collate and highlight any key themes and responses to feedback from quality and safety walkrounds going forward and would detail this in future Patient Safety reports.

Action: Karen McCaffrey

The Committee welcomed the collaborative work with Healthcare Improvement Scotland and extension to the Project Manager post. Members raised no issues around restraint reporting and felt these were appropriate with no issues of concern.

The Committee:

1. Noted the content of the Scottish Patient Safety Programme 12 Monthly Report.

12 INCIDENT REPORTING AND PATIENT RESTRICTIONS

Members received and noted the report on Incidents and Patient Restrictions which provided the Committee with an overview of activity of Incidents and Patient Restrictions within the first quarter 2022/23. The report showed the type and the amount of incidents received through the incident reporting system (Datix). Further, it updated all the restrictions applied to patients during the period 1st April to 30th June 2022.

Professor Thomson provided an overview of the content and advised that trend analysis showed no areas of concern, nor was there anything else of a remarkable event. Members acknowledged the extensive in-depth narrative contained within the report and took assurance from the tracker.

It was noted that the report should be amended to note the increase in equipment failure in Hepma. Mr McConnell requested further context around the category 'other' on page four, under health and safety incidents category. Professor Thomson advised she would clarify this information and ensure it was relabelled within future reports.

Actions: Professor Lindsay Thomson

The Committee:

1. Noted and approved the content of the Incidents and Patient Restrictions Report, pertained to Quarter One 2022/23.

13 STAFFING AND CARE REPORT

Members received and noted the Staffing and Care Report, presented by Mrs McCaffrey, Director of Nursing Operations, which covered the period of June 2022. Mrs McCaffrey provided a brief summary of content of the report for the Committee.

Mr Stuart Currie advised this was an encouraging report in terms of planned and agreed actions being taken forward around recruitment and the importance of the possibility to extend the opportunity for supplementary staffing, given recent positive feedback from staff working within this cohort. Mr Currie also highlighted the importance of word of mouth around working within the hospital given the positive feedback received and that this should be captured as an area of good practice that staff felt welcomed within the organisation. Mr Currie also suggested exploring social media platforms to emphasize how staff are welcomed to the organisation. Mrs McCaffrey advised that herself and Mrs Merson would review the equality initiative around this prospect.

The Chair took the opportunity to address recent media activity reporting of staff requested to work to fulfil deficit shifts on wards. Mrs McCaffrey reassured the Committee that a multidisciplinary

approach was taken to staff shortages on wards during a difficult period and all staff deployed to work with patients had the right level of expertise, and were appropriately trained. She advised that this approach was taken by other forensic care settings where staffing shortages were experienced in the peak of the Coronavirus pandemic.

Mr Gary Jenkins reiterated that in relation to staffing challenges and the expected peaks in Coronavirus infection, the model deployed was in line with the Safe to Start methodology in place to utilise fully trained staff in an effort to avoid ward closures where possible. He advised that in terms of living with Covid-19 and the projection of this, work continued proactively around the operating model and to co-align with medium secure services in this area.

The Committee:

1. Noted the content of the Staffing and Care Report for the period of the month of June 2022.

14 COVID-19 REPORT

Members received and noted The State Hospital Clinical Response to Covid-19 Global Pandemic update report, prepared and presented by Professor Lindsay Thomson.

Professor Thomson advised that since the last report, there were nine formal outbreaks of COVID-19 affecting a total of 51 patients. She advised that work continued to encourage patients to uptake the Covid-19 vaccine, and of the positive feedback received from patients and staff following the introduction of the updated Standard Operating Procedure model for the Management of Suspected / Confirmed cases which moved towards a least restrictive practice as was mirrored in other establishments.

Professor Thomson further advised that surveillance reporting would continue, routed to both the Infection Control Committee and the Corporate Management Team. Lastly, she suggested that Covid-19 reporting continued to the Committee at its next meeting, and could be reviewed thereafter as to whether to continue specific reporting in this regard.

Mr Currie expressed the view that looking beyond the current pandemic and the effective infection prevention and control measures which were now in place were of benefit to the future of the organisation and patient cohort. He also acknowledged the benefit of the least restrictive practice SOP on the management of suspected / confirmed patient cases. Professor Thomson agreed with these points, and also advised that in terms of learning the Forensic Network had prepared reporting for Scottish Government. The Minister for Mental Wellbeing and Social Care had responded to and accepted all recommendations previously submitted. Mr McConnell highlighted it would be of benefit to the Committee to have sight of the Minister's response which Professor Thomson agreed to circulate.

Action: Professor Lindsay Thomson

Mr Moore acknowledged the improvement in the area of patients awaiting transfer from The State Hospital though blockages remained in the system. Professor Thomson highlighted that a paper would be presented to The State Hospitals Board Meeting on 25 August 2022 on patient capacity and contingencies.

The Committee:

1. Reviewed and discussed the update position as was outlined in the report in respect to the clinical management and governance of the organisation in response to the global Covid-19 pandemic and the current State Hospital outbreak.

2. Agreed that a Covid-19 Report be prepared and presented to the next Clinical Governance Committee in November then review decision on continued purpose at that time.

15 DISCUSSION ITEM

Professor Lindsay Thomson introduced and provided a brief introduction to the discussion item around patient activity.

A presentation was delivered by Mrs Merson and Dr Howitt which provided an overview of the definition of activity and the importance of this, what collected data tells us and what actions were taken to promote activity. The presentation also provided an overview of the new Activity Oversight Group, being set up to replace the Operational Model Monitoring Group. and how this would connect with the clinical model. The Committee received this detailed presentation very warmly and found it helpful in supporting understanding and providing assurance.

Mr McConnell thanked Dr Howitt and Mrs Sheila Smith for their very interesting piece of work and noted the system remained in place to operate provisions around patient activity for the patient benefit. He queried whether arrangements could be adapted as and when the patient need required. Mrs Smith advised that a piece of work was ongoing around entering patient's objectives in to RiO in order that these would be reviewed at each case review. This work would continue to progress over the following twelve-month period.

Mr Currie noted the importance of the activity link to patient Care Plans which would ensure delivery of planned activity, whilst improving patient confidence of completion and improve their individual direction of travel.

Professor Thomson acknowledged combining the complexities of the situation and need to build on patient specific individual needs given certain limitations and a move to a more flexible approach on what the hospital was able to offer each patient, as well as being able to move the curriculum around what patients would like to do. Mrs Merson advised that the intention was for the clinical model to support the tailoring of activity better overall.

Members thanked those involved in this area and for the very interesting presentation.

The Committee:

1. Noted the presentation on Patient Activity as was delivered.

2. Agreed the welcomed return of the discussion item on the agenda and that it would remain a standing item going forward.

16 AREAS OF GOOD PRACTICE / AREAS OF CONCERN

The Committee received and noted the template document on Areas of Good Practice and Matters of Concern for 2022/23.

There was discussion around the table and members agreed that a number of areas discussed throughout today's meeting were proven as areas of good practice. Members agreed it beneficial to carry out an exercise in general terms, alongside synergy of papers presented today and discussed, which Mrs Merson agreed to collate with her team.

Action: Monica Merson

Also of particular note, was the operational model introduced in June during a period of staffing deficits during the peak in Coronavirus. During this time, issues were highlighted, addressed in an effective manner with decision making taking at pace during a difficult period.

Lastly, the collaborative work with Healthcare Improvement Scotland to deliver the SPSP programme was an area of good practice and would be reflected in an updated document via version control.

No areas of concern were raised.

The Committee:

1. Agreed on areas of good practice which would be documented going forward.

2. Acknowledged there were no matters of concern raised to note.

17 CLINICAL GOVERNANCE COMMITTEE WORKPLAN 2022/23

Members received and noted the Committee Workplan for 2022/23.

Following review, it was recognised there was no update paper requested on the Clinical Model on today's agenda. Mrs Monica Merson advised that a paper would be presented to The State Hospital's Board Meeting on 25 August 2022 due to the stage of works in progress. Members agreed that Clinical Model update would remain a standing item on future agenda's and updates provided when movement prevailed.

Action: Secretariat

In terms of future 'special topic' discussion items, four areas were identified; (1) clinical model update, (2) Barron Review and Scottish Government Short Life Working Group update, (3) new Observation practices update, and (4) Activity Oversight Group presentation. Members made reference to suggested items 1 and 2 and that updates would be delivered dependant on potential updates available in three months-time.

The Committee:

1. Noted the Clinical Governance Committee workplan.

18 ANY OTHER BUSINESS

Mr Gary Jenkins advised of a BBC documentary due to air on 15 August 2022 which was expected to reference The State Hospital. He further advised that Dr Jana de Villiers had participated in the making of this documentary given her expertise with the Intellectual Disability Service. The Committee wished to thank Dr de Villiers for her support in this regard.

19 DAY, DATE, TIME AND VENUE FOR NEXT MEETING

The next meeting would be held on Thursday 10 November 2022 at 0945 hours via Microsoft Teams.

The meeting concluded at 1235 hours

THE STATE HOSPITALS BOARD FOR SCOTLAND

CLINICAL FORUM

Draft Minutes of the Clinical Forum held at 10.00am on Tuesday 20 September 2022 via Microsoft Teams

Chair:

Dr Sheila Howitt	Consultant Forensic Psychiatrist

Present:

Dr Aileen Burnett	Consultant Clinical Psychologist
Josie Clark	Lead Professional Nurse Advisor

Apologies:

Alan Blackwood	Senior Charge Nurse
Dr Jana de Villiers	Consultant Psychiatrist
Margaret Smith	Head of Corporate Governance & Board Secretary
Marcus Topping	Practice Nurse

In Attendance:

Sandie Dickson	Person Centred Improvement Lead
Ben Green	Clinical Liaison Security Manager
David Hamilton	Social Work Team Leader
Lindsey MacGregor	Lead Allied Health Professional
Kim McLelland	Senior Charge Nurse
Brian Moore	Board Chair (Item 11)
Sheila Smith	Head of Clinical Quality
Fiona Warrington	Clinical Pharmacist
Julie Warren	Personal Assistant (Minutes)

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

The Clinical Forum Chair, Dr Sheila Howitt, welcomed everyone to the meeting. Apologies were noted as detailed above. Members acknowledged the previously scheduled meeting due to take place on 19 July 2022 was not held due to the stand down of non-essential business at that time, however business due for discussion at that time was remitted to today's agenda.

NOTED.

2 CONFLICT(S) OF INTEREST

The Chair highlighted a potential conflict of interest regards agenda item 12 and her role as Clinical Lead within the Clinical Model and Chair of the Clinical Forum. Dr Aileen Burnett volunteered to act as the representative from the Forum at future Clinical Model meetings to ensure a fair representation on behalf of the Forum. Members endorsed this position.

AGREED.

3 ELECTION OF NEW VICE CHAIR

The Forum Chair, Sheila Howitt advised that she would come to the end of her two terms as Chair in January 2023.

Notes of interest from members of Professional Advisory Committees were issued and it was

recognised that Mrs Josie Clark, Lead Professional Nurse Advisor, put her name forward for the Vice Chair position, and this was agreed.

APPROVED.

4 APPROVAL OF PREVIOUS MINUTES

The minutes of the previous meeting held on 17 May 2022 were approved as an accurate record.

APPROVED.

5 URGENT MATTERS ARISING

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

NOTED.

6 REVIEW OF ROLLING ACTIONS LIST

The Forum received the action list and noted progress on the action points from the last meeting. The remainder of actions were completed or on today's agenda for discussion.

NOTED.

7 GROUNDS ACCESS POLICY UPDATE

Mr Ben Green advised that approximately three meetings were held over the summer period to discuss grounds access and provided a brief verbal update from these meetings. Mr Green advised that amendments were agreed with no major changes and the policy was expected to be presented to the September Policy Approval Group. He advised that the agreed policy would be fit for purpose within the future planning for the clinical model. He further advised that it was the planned intention that grounds access would be live within RiO, the electronic patient record. Mr Green advised he would provide an update in two months' time.

Action: Mr Ben Green

NOTED

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

The Clinical Forum Chair advised members that the last meeting had taken place two weeks prior. Discussions at that group was were noted to be around the following topics;

- A team from the Scottish Government reviewed changes to application of benefits, though in terms of The State Hospital, this would not have direct relevance.
- An update from Boards on the retention of nursing staff, the current shortage and the impact on staff morale. A work stream was noted to be in place which was developing at pace.
- The Area Clinical Forum Chairs group would be electing a new Chair from the New Year 2023.

Dr Howitt agreed to circulate minutes from this meeting once available.

Action: Dr Sheila Howitt

NOTED.

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

(a) Nursing and Allied Health Professions Advisory Committee

Members received and noted the minutes of the Nursing and Allied Health Professions Committee dated 16 August 2022. Mrs Josie Clark advised that a recent development session was held and Terms of Reference were reviewed. Focus of the Committee was building momentum at this time and future updates would be provided to the Forum.

NOTED.

(b) Medical Advisory Committee

Members received and noted the minute of the Medical Advisory Committee which took place on 8 August 2022. Of note, was discussion around the high secure women's service within The State Hospital. Members recognised that Mr Gary Jenkins, Chief Executive Officer was due to provide an update at the Forum in November and suggested that a request was made around providing an update for members at that time. The Chair advised she was raised this with Mr Jenkins in advance of the next meeting.

Action: Dr Sheila Howitt

The Medical Advisory Committee meetings were noted to be going well and members raised no concerns.

NOTED.

(c) Psychology Professional Practice Meeting 5 September 2022

Members received and noted the minutes of the Psychology Professional Practice meeting which took place on 5 September 2022. The Forum recognised that the Head of Psychology post was out for advert and of the current pressures experienced within the service. The appointment of a Health Psychologist was welcomed, who was due to commence in the near future.

NOTED.

(d) Update Report from Dentist, GP and Optometric

Updates from the Dentist, GP and Optometric had been received from the Practice Nurse for the months of July and August 2022 which members noted. Dr Howitt advised of feedback from the Responsible Medical Officer cohort of staff that the service was working well with positive comments received from Consultant Psychiatrists on the service.

NOTED.

10 TERMS OF REFERENCE REVIEW / TSH PROFESSIONAL ADVISORY COMMITTEES

This work was noted to be in progress and that an update would return to the Clinical Forum.

NOTED

11 BOARD CHAIR UPDATE

Mr Brian Moore, Board Chair, joined the meeting to provide members with an update on key areas for discussion and development across the hospital at the current time. This included updates on

the recent Ministerial visit to the hospital and the positive feedback received following this. He also highlighted the value and importance of the recommencement of Quality and Safety Walkrounds and opportunity to capturing patient and staff feedback during same.

Mr Brian Moore also provided updates from the Board Meeting held in August, the recent development sessions held at Non-Executive Director level and the benefit of these. Also of note was the agenda underway for the upcoming visit on 21st October 2022, from Caroline Lamb, Director General for Health and Social Care, accompanied by Scottish Government colleagues Mr John Burns, Chief Operating Officer and Mr David Miller, Chief People Officer. Lastly, he encouraged members on the uptake of the Winter Flu and Covid-19 vaccines which were underway at that time.

Following query from members on the positon of the high secure Women's Forensic Service within The State Hospital, Mr Moore confirmed that this continued to be an area of development. The Forum Chair thanked Mr Moore for his comprehensive overview on recent matters.

There was discussion around the table about the challenges and pressures experienced on nurse recruitment. Mrs Kim McLelland, Senior Charge Nurse, took the opportunity to advise she recently took an active role in this area and that ten new members of nursing staff were due to commence in the near future, and additionally that this was an improving picture and the Safe to Start process was noted for safe delivery of care. Mrs Josie Clark added that there had been a high volume of applications for nursing roles during the recent recruitment round. The Forum also considered the impacts of unplanned absences, such as sickness on the delivery of services. It was also noted that staff had demonstrated flexibility to help support essential services.

There was discussion on the increasing requirements to enter data on the electronic patient records system, and the balance with time spent on therapeutic activity. Mr Brian Moore acknowledged that this had been highlighted during a recent Quality and Safety walkround. The Forum discussed the benefit of the availability of rich patient data, though staff were being asked to spend more time on record entry and the balance of resources available. Mrs Clark agreed to raise this issue via the Patient Safety Group agenda alongside the outcome measures. Mr Brian Moore thanked the Clinical Forum for their feedback.

Action: Mrs Josie Clark

Following on from this discussion, there was wider consideration discussion of governance reporting, especially at times of service pressure and in the context of the recent stand up of the Operational Planning Group as well as linking operational matter to the Board and its committee for assurance. Mr Moore was again thanked for attending the Clinical Forum, and for his helpful comments before leaving the meeting.

The Clinical Forum Chair sought comment from the Forum on the action to take forward in terms of the data issues raised. Following discussion around the table, members agreed it beneficial to follow up today's discussion by noting this to Mr Brian Moore, Board Chair, and Dr Howitt agreed to do so. Members also agreed it beneficial to highlight the Clinical Forum's feedback to the Corporate Management Team, and Dr Howitt would do so.

Actions: Dr Sheila Howitt

Members of the professional advisory committees also agreed it would be of benefit to take forward consideration and discussion of this at future meetings of each professional committee.

Action: Aileen Burnett / Sheila Howitt / Josie Clark

NOTED.

12 UPDATE ON CLINICAL MODEL

Members were provided with a verbal update on progression of the Clinical Model by Dr Sheila Howitt, as Clinical Lead. Dr Howitt advised that a Short Life Working Group was scheduled to meet next week where Heads of Service were asked to consider how works would impact their individual services and report back. Helpfully, flash reports on clinical model updates would be provided on a monthly basis via the Staff Bulletins and presented at front of the hospital reception area. Taskforces for each discipline would also be set up for collaborative input, alongside the opportunity for staff to provide comments around the set activity targets.

NOTED.

13 DISCUSSION ON PREPARATION OF ANNUAL REPORT 2022/23 TO NHS BOARD MEETING

The Chair advised she would seek confirmation from the Board Secretary of the due date for the Clinical Forum Annual Report.

Action: Dr Sheila Howitt

NOTED.

14 AOCB

Members raised no other urgent competent business.

NOTED.

15 DATE AND TIME OF NEXT MEETING

The next meeting of the Clinical Forum would take place at 10am on Tuesday 15 November 2022 via Microsoft Teams.

Meeting concluded at 1150 hours

Paper No. 22/117

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 December 2022
Agenda Reference:	Item 17
Sponsoring Director:	Director of Workforce
Author(s):	Head of HR
Title of Report:	Workforce Report
Purpose of Report:	For Noting

1 SITUATION

This report provides an update on overall workforce performance to 30th November 2022.

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

2 BACKGROUND

As previously explained, The State Hospital use a dashboard system called Tableau which is very much in the developmental stage. The Workforce Dashboards are still in 'test mode', however, it is anticipated that these will be available on the active system for all managers to access for their own areas by the end of January 2023. This will have a link similar to eESS and SSTS. The system has the ability for managers to set up subscriptions to reports on particular days so that they receive an auto-notification.

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

The information is provided to the end of November 2022, with the exception of the national figures.

3 ASSESSMENT

- Absence and Attendance Management

    - The information available shows that the absence rate for November 2022 is 8.69%. The rolling year average is 6.44%.
    - 48 staff were being managed through the formal stages of the Attendance Policy and 32 staff were off on long term absence.
    - Key reasons for short term absence were anxiety/stress/depression, cold/cough/flu, back problems and gastrointestinal. For long term absence, the main reasons were anxiety/stress/depression, other musculoskeletal and other known.
    - Covid related absence accounted for 0.64% of all absence.
    - Daily updates on all staff absence are now generated via Tableau and sent to all managers who have requested this report.
    - Detailed work continues to be undertaken in targeted departments looking at trends in absence reasons and patterns of absence, using this information to identify what supports can be put in place to support individuals in remaining at work as well as supported back to work from absence.
    - The HR team regularly attend the SCN forum providing an opportunity for this group to ask questions on the Attendance Policy and explore common questions such as timeframes for meetings, monitoring periods and follow up meetings.
    - Development work on policy training for managers will begin in January. This will be collaboratively with other NHS Boards.

- Recruitment

    - 7 separate posts were advertised in November, including an advert for multiple staff nurses. There are 16 individuals with confirmed start dates and a further 6 with conditional offers pending checks and clearances.
    - Work is ongoing to consider the KPI for recruitment to ascertain how the timelines can be reduced.
    - Progress has been made in developing a recruitment brand for TSH, with improved social media presence relating to vacancies.

- Supplementary Staffing

    - 59.28 WTE supplementary staffing was required through overtime or excess hours for the whole organisation. 38.38 WTE supplementary staffing was required for Nursing.
    - Work will be overseen by the Workforce Governance Group on analysing the use of overtime / excess hours and supplementary staff.

- Employee Relations

    - Three new informal employee relations cases were identified and no new formal cases. There were three ongoing cases: one case is on track and two cases were delayed and are now proceeding to conclusion. The commissioning managers have been kept up to date where there have been delays in the process and have supported discussions to take these forward.

- Turnover

    - Six staff ended their employment at The State Hospital in November 2022. This brings the total number of staff who have left within financial year 2022/23 to 55 to date.
    - Exit interviews are offered to all staff on leaving the organisation. A trial is underway with MS Forms enabling staff to complete the exit interview through this function. Letters are sent to staff who are leaving offering the option of completing their exit questionnaire via a link or a QR code.

- PDPR Compliance

As at 30 November 2022:

- The total number of current (i.e. live) reviews was 528 (86.1%).
- A total of 59 staff (9.6%) had an out-of-date PDPR (i.e. the annual review meeting is overdue).
- A further 26 staff (4.3%) had not had a PDPR meeting. Staff in this group are predominantly new staff with an initial set-up review meeting overdue.
- Compliance has increased by 1.5% since the previous report in October 2022.

4 RECOMMENDATION

The Board are invited to note this report.

MONITORING FORM

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

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 December 2022
Agenda Reference:	Item No: 18
Sponsoring Director:	Director of Workforce
Author(s):	Director of Workforce
Title of Report:	Whistleblowing Update
Purpose of Report:	For Noting

1 SITUATION

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

2 BACKGROUND

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

3 ASSESSMENT

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

This is Quarter 2 update for 1st July 2022 to 30th September 2022. No Whistleblowing cases were raised during this quarter.

An action plan has been developed to further improve understanding, awareness and process in relation to the Whistleblowing Standards and continues to be monitored.

The INWO attended a Board Development Session in September. They provided a helpful update on the Standards and also the responsibilities of the Board and Non-Executives in this process. There has been an appointment to the Non-Executive Whistleblowing Lead and this will be announced over the next week or so with a start date of December.

TSH Hospital participated in the "Speak Up Week" which took place on 3-7 October 2022. Staff Bulletins were email to the service from the Chair, Chief Executive and Employee Director amongst the updates.

Noticeboards provided information to staff on the Standard and the main one was placed in the front reception area. This also provided staff with specially branded pens, notepads and post-it notes, highlighting that “Speaking up is in everyone’s interest”. A Wordsearch competition was also undertaken and the winner of a fitbit watch was a Catering Assistant.

Information relating this to initiative was also highlighted on social media and general feedback to this initiative has been positive.

4 RECOMMENDATION

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

MONITORING FORM

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

THE STATE HOSPITALS BOARD FOR SCOTLAND
STAFF GOVERNANCE COMMITTEE

Minutes of the meeting of the Staff Governance Committee held on Thursday 18 August 2022 at 9.45am via MS Teams.

Chair:	
Non-Executive Director	Pam Radage
Present:	
Employee Director	Allan Connor
Non-Executive Director	Stuart Currie
Non-Executive Director	Cathy Fallon
In attendance:	
Head of HR	Audrey Bevan
POA Staff Side Representative	Alan Blackwood
Training & Professional Development Manager	Sandra Dunlop
Chief Executive	Gary Jenkins
Lead Nurse	Stuart Lammie
Director of Workforce	Linda McGovern (nee Davidson)
UNISON Staff Side Representative	Michelle McKinlay
Head of Planning & Performance	Monica Merson
Board Secretary	Margaret Smith
PA to Director of Workforce	Rhona Preston ***(Minutes)***

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

Pam Radage welcomed everyone to the meeting, noting formal apologies from Brian Moore, Board Chair.

2 CONFLICTS OF INTEREST

There were no conflicts of interest noted.

3 MINUTES OF THE PREVIOUS MEETING

The Committee approved the Minutes of the previous meeting held as an accurate record of the meeting.

4 ACTION POINTS AND MATTERS ARISING FROM THE PREVIOUS MEETING

The Committee noted the action list, and the progress made in this respect. Work continues to be progressed to help provide further support to staff in relation to sickness absence. This was focused on detailed analysis of patterns of absence and the additional learning that could be taken from this. Further reporting would be brought back to this Committee at the November meeting.

Members agreed to close the ER Reporting action, a narrative is now included explaining any delays.

STANDING ITEMS

5 WORKFORCE REPORT

The Committee received the report as summarised by Audrey Bevan, Head of Human Resources, who advised members that this remains a work in progress document to ensure it contains all the information required.

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

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

Members noted the overview provided and agreed the information within the report was very informative and provided helpful qualitative data.

There was a lengthy discussion and concern raised for the main recorded reason for long term absence being anxiety/stress/depression/other psychiatric illnesses with Stuart Currie asking if this was a stand-alone issue or whether other Boards were experiencing similar issues. A request was made for a paper to be presented to the November meeting detailing; Comparison of reasons across other Boards; Reasons for Anxiety, Stress and Depression and themes within these; What preventative measures are in place and are additional measures required. Discussions also included reasons being recorded on SSTS by Managers, the importance of reasons being recorded is recognised.

Both Audrey Bevan and Linda McGovern shared some national discussions and work-streams that are taking place around Mental Health and Wellbeing, Major Trauma and Occupational Health support services together with training for Managers to provide support. This information will also be included within the report presented to the November meeting.

ACTION: L McGOVERN and A BEVAN

It had been requested at the previous meeting to add Health and Wellbeing as a standing agenda. Due to annual leave staff members were unable to attend therefore members were advised that this will be added to future meetings as a standing item with regular updates provided by the Wellbeing Staff. Lorna Fyfe, Staff Care Specialist will be invited to attend the November meeting to update on her first impressions and observations together with ongoing workstreams taking place through HR and Wellbeing including a support leaflet that is work in progress. Collaborative working with staff side on this leaflet is recommended as advised by Alan Blackwood who explained of the many support services available to staff through their respective unions.

The Committee noted the report thanking those responsible for this improved update.

6 PERSONAL DEVELOPMENT PLAN REPORT

The Committee received the Personal Development Planning & Review (PDPR) report which reported to the 31 July 2022. Sandra Dunlop, Training and Professional Development Manager provided a summary, noting that the rate of compliance had increased to 83%.

A total of 61 staff (10.1%) had an out-of-date PDPR (i.e. the annual review meeting is overdue) – a decrease of 8.6%.

Included within the report was compliance levels as requested at the previous meeting around comparator information prior to the pandemic.

A further 42 staff (6.9%) had not had a PDPR meeting – an increase of 2% from the previous update. Staff in this group includes new staff who have an initial set-up review meeting overdue (this meeting should take place at the end of the 3-month induction period), plus staff who have been in post for over 12-months but have not had a PDPR meeting since joining the organisation. Staff in this group includes 22 staff who have been in post between 4 to 6 months, 14 staff who have been in post between 7 to 12 months, and 6 staff who have been in post for more than 12 months.

Although there is no data available from other Boards to allow a comparison, further to discussions held between Sandra Dunlop and colleagues from across other Boards, it was noted that the State Hospital are holding steady with compliance levels and compare well. The primary reasons for any dips are due to staff absences and/or staffing pressures. Reassurance was given to members that continued support is available to staff and managers when required.

There was concern raised from Stuart Currie, Non-Executive Director who recognises that although meetings are taking place he explained the importance of 80+% not becoming the norm and recognises that there will always be something that gets in the way of ensuring a higher compliance rate. He emphasised the importance of the discussions between Managers and their staff, this is a key part of their role and encourages them to continue with both formal and informal conversations. Members agree these play an important part in people's wellbeing and should not be underestimated how important the informal conversations can be. Sandra Dunlop advised members of the strong commitment she knows many Managers have and who recognise the importance of this as being part of their role.

Gary Jenkins advised members of his own compliance levels within his area and recognises the pressures that can result in these meetings not taking place as planned however with a move back to business as usual he anticipates an improvement in his own departments compliance.

The committee noted the report and agree that all conversations held between Managers and staff are important to all involved for their wellbeing and should take place as planned/scheduled throughout the year and in-between.

7 WHISTLEBLOWING UPDATE

The Committee received the Whistleblowing update for Quarter One, 1 April 2022 to 30 June 2022 there were no whistleblowing cases raised. Members also received the Action Plan that has been developed to further improve understanding, awareness and process in relation to the Whistleblowing Standards. This outlined the following measures;

- All staff who are likely to receive Whistleblowing concerns such as Managers and Confidential Contacts should complete both modules of the TURAS training programme in addition to familiarising themselves with the details of the National Whistleblowing Standards, April 2021.
- Confidential Contacts should be recruited and fully trained.

- The identity and roles of the Non-Executive Whistleblowing Champion and the Director with specific responsibility for Whistleblowing should be promoted more widely throughout The State Hospital.
- A Whistleblowing Liaison Officer should be designated with specific responsibility for the introduction of the Standards across the organisation, in addition to the recording, reporting and monitoring of cases.
- An internal Operating Procedure should be developed and implemented.
- Sources of support for both Whistle-blowers and others who may be implicated or involved in complaints, such as witnesses, should be established.
- A Communication Plan aimed at raising awareness of the Standards should be developed and implemented.
- A culture where complaints and concerns are encouraged and welcomed by management should be developed.

Members agreed the importance of these measures and are encouraged that this work can move forward now that meetings are to be stood up.

Linda McGovern advised of work being carried at Lothian around this and the team they have supporting it. Due to the size of our Board it would require to look slightly different, further information on this to be gathered and shared appropriately.

Margaret Smith advised members that interviews are scheduled to take place by the Scottish Government to recruit a non-executive whistleblowing champion with the planned start date of early December. However, it was noted that as an interim position all non-executive directors are available to discuss any whistleblowing concerns, it is important all people have a safe place/space to talk.

The committee noted the report and update provided.

ITEMS FOR DISCUSSION

8 RECRUITMENT STRATEGY 2022-2024

The Committee received the Recruitment Strategy 2022-2024. Recruitment and retention of good staff remains a challenge ensuring the organisation meets key targets but is flexible enough to meet future agendas for health and social care. This was reflected in the Interim Workforce Plan for 2021-22 and work is continuing on the 3-year Workforce Plan for 2022-25 as set out in the Workforce Plan.

The Hospital is required to develop a streamlined process for recruitment alongside the development of different recruitment methods in order to support effective recruitment moving forward, recognising that the available workforce will be sought after by a number of potential employers. The Strategy describes how the Hospital will develop adaptive and modern recruitment processes to ensure quality staff who exhibit key skills, experience, values and beliefs to undertake their job roles, effectively, whilst demonstrating their ability to deliver compassionate holistic care.

The strategy outlines; Recruitment systems; Workforce Planning; Quality of recruitment experience / induction; Visibility of TSH and Retention.

It is recognised that the use of social media and communications will be crucial to future recruitment, this will be supported by the Communications Team when fully staffed as recently advertised. The Recruitment Strategy will be implemented over financial years 2022/3 and 2023/4 and will follow national and local guidance and policy, taking part in any internal and external reviews as necessary.

The committee noted and agreed to support the strategy.

ITEMS FOR INFORMATION

9 APPROVED MINUTES FROM PARTNERSHIP FORUM

The Committee received and noted the approved minutes from the meeting that took place on 26 April and 24 May 2022. More recent minutes were not available due to meetings being stood down as a result of essential business only.

It was noted that members were encouraged to read the update on robust discussions on PDPRs at the Partnership Forum.

10 APPROVED MINUTES FROM HR AND WELLBEING GROUP

The Committee received the approved minutes from the meeting that took place on 12 April 2022. More recent minutes were not available due to meetings being stood down as a result of essential business only.

It was noted that members were pleased to know that other wellbeing support measures are being discussed and introduced for those staff who cannot leave their ward area. This is encouraging to see and to know this is being discussed and solutions sought to help this staffing group.

11 WORKFORCE PLAN 2022 - 2025

The Committee received the Workforce Plan 2022 – 2025, Gary Jenkins advised members that this was for information only at this stage. This was submitted to the Scottish Government on 29 July 2022 and will be presented to a future meeting following comments received and endorsement at a future Board meeting.

The Workforce Plan covers the five pillars of workforce planning; Plan; Attract; Train; Employ; Nurture and includes a 13-point action plan.

Members found the report very helpful and are encouraged to see there will be a Workforce Governance Group.

There was discussion around the inclusion on student placements and their positive experience together with those recruited as Cathy Fallon highlighted this is something that has been done very well and should be included in the report. Gary Jenkins advised members of the very positive comments received from those students that met with Karen McCaffrey, Director of Nursing and AHPs and agrees that the Hospital should be seen as an employee of choice, despite its challenges it is good organisation to work within and should be promoted as such. Monica Merson echoed the comments received about students feeling welcomed during their placements and feeling they are part of the team.

Pam Radage welcomed this feedback and found the document very useful, together with the Recruitment Strategy also presented at today's meeting, she feels these two documents link and work very closely with each other.

Future recruitment was discussed at length with suggestions made about a focus on targeting local areas, checking in with local colleges, it is recognised that more needs to be done on local reach.

Alan Blackwood asked about looking into why people are leaving especially those staff who have only been at the Hospital less than 12 months, and what learning there is from their exit interviews and who receives this feedback. Gary Jenkins recognises the requirement for a more effective process with exit interviews and would support an impartial exit interview. Linda McGovern agreed this is an area that she will take forward and discuss with Audrey Bevan and the HR Team.

ACTION: L McGOVERN and A BEVAN

12 ANY OTHER BUSINESS

Alan Blackwood asked whether iMatter should have been on today's agenda as historically he understood it was discussed at this Committee. Linda McGovern advised that iMatter is raised at the Committee however it features on agreed meeting dates as laid out in the approved Workplan for the year. This item is scheduled to be discussed at the November meeting.

13 DATE AND TIME OF NEXT MEETING

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

Paper No. 22/119

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 December 2022
Agenda Reference:	Item No: 20
Sponsoring Director:	Chief Executive
Author(s):	Board Secretary
Title of Report:	Corporate Governance Improvement Action Plan
Purpose of Report:	For Decision

1 SITUATION

This report provides an update on The State Hospital (TSH) Corporate Governance Improvement Actions Plan to support the key corporate governance priorities as part of the NHS Scotland Blueprint for Good Governance. This has been reviewed during 2022, and updated national guidance is to be circulated to NHS Boards in the near future by Scottish Government.

2 BACKGROUND

The five key areas of the improvement plan are outlined as follows:

- Setting the Direction
- Holding to Account
- Assessing Risk
- Engaging Stakeholders
- Influencing Culture

The Improvement Plan (attached as Appendix A) sets out the relevant workstreams under each of these five key areas.

3 ASSESSMENT

Item 1 – Effective rostering within the nursing directorate:

The Chief Nursing Officer (CNO) has contacted all Health Boards to deliver roadshow sessions to provide an overview of the Health and Care (Staffing) (Scotland) Act. The State Hospital's session has been arranged for 26 January 2023. The CNO office has advised that they are keen to ensure that engagement continues with Boards as implementation approaches, so that any concerns or questions can be addressed. This will support preparations for the commencement of the legislation, and the State Hospital has applied to be a pre-implementation Board. This will align with implementation of e-rostering across NHS Scotland, subject to national agreement and leadership of this project.

The Workforce Governance Group is now established within TSH, commencing in January 2023. This will to take oversight for workforce governance, including health and care staffing legislation, and applying consistent principles to lead organisational development and change across all directorates. This group will report directly to the Corporate Management Team, linking with Partnership Forum and providing a forum for the development of assurance reporting to the Board and its committees, particularly Staff Governance Committee.

Item 2 – Patient Physical Health

The Board agreed to use this mechanism to help track progress in this respect, given the importance of this in achieving the Board's key mission to improve patients' physical health.

The Supporting Healthy Choices Project Manager has now been recruited and is now in post. Detailed progress reporting will be presented to the Board at its next meeting in February.

The Activity Oversight Group (encompassing all activity but including physical health) has been established led by the Director of Nursing and Operations, and the Board receives a regular update through the Quality Assurance and Quality Improvement report.

Item 3 - Northern Ireland funding

Following meetings between the Director of Finance and EHealth and the Northern Ireland Department of Health, in relation to cross-charging for patients from Northern Ireland; further research into the background and historical agreement has raised the possibility of governmental agreement being in place, which would prevent cross-chargng. This has been escalated to Scottish Government at this stage and an update on the position will be brought back to the Board.

Item 4 – Review of the performance metrics framework:

The Board has received newly formatted reporting in the past year, as well as input from the Board Development team at NHS Education for Scotland, focusing on performance reporting as part of the Active Governance workstream.

Quarterly performance review meetings are now embedded into routine practice, led by the Chief Executive with each Director and their direct reports. These include performance against the Annual Operating Plan and Delivery Plan and any emerging issues.

The Board is asked to consider whether the review of the performance framework has been sufficiently developed to enable this action to be closed as part of this plan, and for quarterly performance reporting to continue directly to the Board.

Item 5 - Self-Assessment for Committees

The Staff Governance Committee asked for a self-assessment tool to help measure its effectiveness. This was rolled out during November and resulted in a positive participation rate. A similar exercise will be rolled out to the Clinical Governance Committee in January 2023. Reporting will then be brought to each committee meeting in February 2023.

The Audit Committee already completes this annually, and this was reported to its meeting in October 2022.

Items 6/7 - Board and Committee Meeting Arrangements

It is suggested that these items could be compiled into one action, relating to how Board and Committee meetings are arranged during 2023.

The Board reviewed its arrangements, in the context of current and potential pressures during winter 22/23, meaning that MS Teams remains the preferred option in the short term. There was agreement to continue on teams during winter period 2022/23. This will allow testing of the equipment already available within the Boardroom in relation to hybrid meetings, as well as the option of external locations to the hospital itself. The focus continues to be on the effectiveness of the arrangements to support governance oversight and to encourage public attendance. A further update will be brought back for consideration in spring 2023.

4 RECOMMENDATION

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

- Close performance reporting

Author:
Margaret Smith
Board Secretary - 01555 842012

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	In support of the Corporate Governance Blueprint, and development of a Once for Scotland approach for cohesive governance across NHS Scotland
Workforce Implications	None identified to date
Financial Implications	None identified to date
Route To Board Which groups were involved in contributing to the paper and recommendations.	Board requested as part of workplan – to enable reporting to Scottish Government
Risk Assessment (Outline any significant risks and associated mitigation)	None identified to date – this report supports good governance and considers overview whilst each workstream provides reporting and risk are outlined therein.
Assessment of Impact on Stakeholder Experience	Implementation will benefit stakeholder engagement through the workstreams indicated in the improvement plan
Equality Impact Assessment	Not required to be formally assessed
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	No impact identified
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One X There are no privacy implications. □ There are privacy implications, but full DPIA not needed □ There are privacy implications , full DPIA included.

THE STATE HOSPITALS BOARD FOR SCOTLAND - IMPROVEMENT PLAN **Appendix A**

BLUEPRINT FUNCTION		ACTION	LEAD	ASSURANCE SYSTEM	TIMESCALE	PROGRESS
SETTING THE DIRECTION	1	Review of effective rostering system within nursing as component of focus on effective workforce utilisation and safe staffing legislation.	Director of Nursing, AHPs and Operations	CMT	Update to February 2023 Board meeting	**December 2019:** Work to ensure effective rostering is in place with the support of electronic systems. Testing of SSTS eRostering module in one ward with wider rollout planned. Restrictions on effective rostering remain due to fixed shift pattern; alternative, flexible shift pattern introduced for all new appointments to ward nursing posts which increased capacity Internal Audit planned for Jan 2020. **Update: February 2020** RSM undertook audit 6th to 10th January 2020, range of actions linked to this point accepted for progression. **Update: December 2020** Work restarted - further planning and review underway in conjunction with interim management structure. **Update April 2021:** Work with the National Workforce Team has generated several pieces of work to streamline processes including potential adaptations to rostering and shift patterns to improve rostering, create capacity and reduce overtime. This workstream will continue to be progressed in Partnership during 2021. Full update to Board Seminar in May 2021 (deferred). **Update August 2021:** Dedicated reporting to Staff Governance Committee on implementation of legislation, dedicated

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

						handovers and to service delivery / impacts on patient experience currently underway. Bank - Recruiting underway to Nursing Bank among existing staff group with interviews for first cohort planned, and SLWG to take forward to monitor development and impacts and potential to grow thereafter. **Update August 2022:** Safe staffing legislation & self-assessment remains paused. Engagement with the national team regarding e-rostering and exploring options regarding project management support for this work. Work progressed on shift patterns, especially proposals for supporting handovers. Nurse Bank re-flagged as Supplementary Staffing register(SSR). This is being actively progressed with ending of fixed term interviews for nursing staff within the nursing pool, and offer of joining SSR. This renewed offer has been positively received to date. SLWG continues to have oversight of this work. **Update December 2022:** -The CNO office will be delivering a roadshow to the Board in January 2023, and TSH applied to be pre-implementation Board for Health and Care Staffing. -Progressing TSH involvement in national e-rostering as national project.

						-Workforce Governance Group now established within TSH to take oversight across workforce governance, reporting to CMT, linking with Partnership Forum and developing assurance reporting to the Board and its committees.
	2	Patient Physical Health	Medical Director	Board	Added October 2022. Update at February 2023 Board Meeting	**Update August 2022:** The Board is asked to consider adding this to the plan - this area was highlighted as part of formal feedback following the Ministerial Annual Review in April 2022. Agreed. **Update December 2022:** -Project Manager now recruited and in post for Supporting Healthy Choices. Further progress update will be presented to the Board at its next meeting in February. -The Activity Oversight Group (encompassing all activity but including physical health) has been established to lead.
HOLDING TO ACCOUNT	3	NI Patients – Cross charging.	Director of Finance and eHealth	Board	Added October 2022, awaiting national guidance	The Board is asked to consider adding this to the plan - this area was highlighted as part of formal feedback following the Ministerial Annual Review in April 2022. Agreed. **Update December 2022:** This has been progressed at Board level with direct contact to NI, and then escalated to Scottish Government for consideration.

	4	Review performance framework and assurance information systems to support review of performance.	Head of Corporate Planning	CMT	To consider as completed	**On Track -** Strategic Review of Performance underway with draft performance framework in development based on balanced scorecard approach of better health better care, better value and better workforce. Operational definitions for suggested KPI's being developed with associated data sources identified. **Update: December 2020** Presentation to Board in November 2020, work progressing with oversight through CMT **Update April 2021**: Format of KPI report changed to provide clarity on KPI's performance and describe the areas for improvement. Data map developed to illustrate where data is reported across governance and management groups. PuMP pilot being taken forward with HR to support alignment of performance improvement and reporting of KPI's in line with Organisational priorities and linked to departmental priorities. **Update August 2021. P**uMP rolled out to EHealth following the HR programme, and underway. Performance Workbook created across directorates and linked to governance. Strategic Planning and Performance Group set up and met for first time in August 2021, reporting line to the CMT. Link also made to Active Governance workstream for board development session planned for November 2021. Further update to Board in due course.

						Update December 2021: Board Development Session on Active Governance scheduled for 13 January 2022, and Board will consider this action further following that. **Update April 2022:** Session delayed due to extreme pressures during January – now scheduled for 3 May 2022. **Update August 2022:** Following the Board Development session on Active Governance, the Quarterly and Annual Performance Reports have been revised with slight amendments made. Development of the Performance Management Framework within TSH has continued and an agreement reached at CMT Development day to introduce 1/4ly Directorate Performance Management meetings with Directors. These meetings will provide the opportunity for a constructive deep dive to understand how each Directorate is performing against our Annual Operating Plan, the current operating context and new and emerging issues. This will also include a review of the workforce and financial position. **For Discussion**: Board is asked to provide feedback on performance reporting following current quarterly committee meeting and to this Board meeting. **Update December 2022:** Directorate performance Reviews now firmly established as quarterly events, led by CEO. Reporting framework reviewed including active

						governance workstream, and quarterly updates to the Board. **Board asked to consider whether this item can be closed on this plan.**
	5	Self- Assessment tool for Governance Committees	Board Secretary	Board	February 2023	**Update August 2022**: Staff Governance Committee asked for a self-assessment tool to be shared, to help them consider effectiveness. This already exists for Audit Committee. Agreed this is rolled out to both Staff Governance Committee and Clinical Governance Committee. **Update December 2022:** Self-assessment circulated and completed for SGC, and will be rolled out for CGC early 2023. Reporting will then be brought to each committee in February.
ENGAGING STAKEHOLDERS	6	Encourage carers / volunteers /staff / local population to attend public Board Meetings through additional promotion and links with local community.	Board Secretary	Board	Review April 2023	**On Track** – through promotion of external Board Meetings /Annual Review session in 2020. **Update: December 2020** Reviewed in Board Seminar November 2020, and awaiting national guidance. Local review to be taken forward to engage virtually. **Update: February 2021**: Board agreed value of digital means of engagement and further work to be take forward to enable this to be taken forward linking to attendance by patients as well. **Update August 2021:** Board to consider further in September Development Session

						Update December 2021: Board received presentation in development session to review the options and consider within context of continuing impacts of Covid-19. Decision to necessarily pause until Spring 2022. In meantime encouragement given through CMT to staff to attend as observers in digital meetings when possible. **Update: April 2022:** Board noted will consider move towards change to how to manage meetings based on previous presentation to board on exploring options including hybrid meetings, and to compare to other NHS Boards. To consider the timescale for any change. **Update August 2022:** Range of options and benchmarking to current practice in other Boards presented to this meeting to allow the Board to consider its way forward – including virtual/hybrid/ in –person or combination of options. This is for Board and Committees meetings as well as development sessions. **Update December 2022:** Agreed to continue on teams during winter period 2022/23. Testing being made re the system within Boardroom and feasibility of hybrid meetings for 2023. Re-consider off-site meetings in spring 2023, and how this will serve public attendance.

	7	Hold two Board Meeting each year at external locations to promote role as national Board.	Board Secretary	Board	Combine with (6) review April 2023	**Update: February 2020:** Board Meeting 27 February in Lanark Memorial Hall, digital participation under review. **Update August 2021:** Board to consider further in September Development Session **Update December 2021:** detailed consideration by Board in context of Covid-19 in development session, on hold to spring 2022. **Update April 2022:** Discussion as per item 12 above – consider planning for this in future. **Update August 2022:** Board Discussion as previous item. **Update December 2022**: As previous item – suggest combine these into one action.
	8	Annual Review - Public Meeting to be held outside of the hospital to help engage public engagement and attendance.	Board Secretary	Board	Pending national guidance	**Update: December 2019:** Plan to be progressed as part of Annual Review. The review in 2020 was redesigned due to Covid-19. Awaiting national guidance for the current year. **Update December 2021:** Confirmation of virtual Annual Review for 2020/21, took place 5 April. This will depend on national guidance for 2021/22 review arrangements. **Update August 2022:** Awaiting guidance from Scottish Government on format of Annual review 2021/22. Minister for Mental Wellbeing and Social Care visited informally on 10 August, and toured the hospital meeting patients and staff. **Update December 2022:**

						Indication that Annual Review will be late spring 2023, with guidance to follow.

Record of closed actions:

BLUEPRINT FUNCTION		ACTION	LEAD	ASSURANCE SYSTEM	TIMESCALE	PROGRESS
SETTING THE DIRECTION		Reconfirm the Board's strategic direction, and communicate this through the Strategy Map and development of	CEO	CMT	June 2019	**Completed:** Strapline finalised following hospital wide competition. Strategy Map reviewed as part of review of Corporate Objectives.

		strapline statement for corporate documents.				
		Development of more robust processes to compare planned and actual spend and to account for any variance.	Director of Finance and eHealth	CMT /Board	September 2019	**Completed:** Process in place- Planned and actual £ spend per budget line reviewed with each individual budget holder on a line-by-line basis from the 2019/20 mid-year 6-month reviews (30/9/19) – a summary of any significant or material variances is collated to be reported as appropriate.
HOLDING TO ACCOUNT		Ensure compliance with new national guidelines in management of Executive pay and performance through remuneration Committee approval for annual ESM pay and performance cycle.	Chair /Interim HR Director	Remuneration Committee	Ongoing	**Completed**
		Ensure implementation of attendance management policy through support from HR to line managers help identify and act upon patterns of absence. Continued implementation of the action plan developed through the Attendance Management Improvement Task Group (AMITG).	Interim HR Director	CMT	Ongoing 2019/20 – revised and completed	**Completed:** Once for Scotland Workforce Policy Implemented. Training for Line Managers and HR Managers delivered. Update presented on attendance management to each Board Meeting. Improvement activity now directed by the HR and Wellbeing Group.

		Implementation and compliance with Once for Scotland HR policies within TSH. Focus on policy awareness through completion of metacompliance / staff bulletins/ staff training in Single Investigatory process.	Interim HR Director	Partnership Forum/CMT	New: April 2022 national target	**Completed:** TSH readiness for planned implementation of phase 2 for April 2022. HR and Wellbeing Group is now well established and will support links with Partnership Forum/ Staff Governance Committee to ensure appropriate governance, with updates to the Board if required.
		Blueprint Improvement Plan to be placed on Board Workplan for review at each Board Meeting.	Chair	Board	June 2019	**Completed**
ASSESSING RISK		Further development of risk management with focus on risk register to ensure this is clearly defined with set of mitigating measures against each risk which also have a focus on improvement actions.	Director Security, Resilience and Estates	Audit Committee / Board	New: June 2021	**Completed:** Work progressed to review the Corporate Risk register and link to development of local registers throughout TSH. Regular reporting of Corporate Risk Register to Board and tracked through monthly reporting at CMT and quarterly at OMT. Local Risk tracked and link made to CRR.
		Promotion of The State Hospital as an employer in the local area.	Interim HR Director	CMT	New: August 2021	**Completed** Full range of recruitment activity in place.

		Increase number of modern apprenticeships. Participate in local school careers events, local and university recruitment fairs.				
INFLUENCING CULTURE		Define culture in The State Hospital in terms of key strengths and weaknesses - take forward through development sessions	CEO	Board	New: August 2021	**Completed:** **Update: February 2020** Progressed in conjunction with response to Sturrock and Clinical Model Review – Culture, Values & Behaviours, Leadership workstream led by CEO. **Update: December 2020** Workstream re-formulated and developed more widely under Recovery and Innovation Group during Covid. Planning in place for development of this framework in spring 2021, and reporting to come to Board as part of workplan. **Update: April 2021** A programme of work, from the themes identified through the staff engagement activity has been taken forward. Oversight of the Recovery and innovation group is through CMT, and updates to all staff through bulletin. Future developments will connect through the staff HR and Wellbeing group **Update: August2021:** Workstream led through HR and Wellbeing. Staff wellbeing reporting

						comes to Board as part of covid reporting, with dedicated reporting to replace this at end of pandemic as part of overall workforce reporting/ workplan.
		Implement a Staff Recognition Scheme for long service as well as individual contribution to the organisation.	Interim HR Director	CMT	September 2019	**Completed**- first ceremony 24 October 2019.
		Embed a culture of quality across the organisation through initiatives such as TSH3030, Quality Forum and sharing our work more widely.	CEO	CMT	February 2020	**Completed and Board now gets full updates at each meeting.**
		Senior Management visibility through regular front line staff engagement meetings with CEO / Directors' Group - plan a calendar of events to ensure regular engagement.	CEO	CMT	New: **Review April 2022**	**Update: December 2019** wider engagement across TSH – progressed in conjunction with response to Sturrock and Clinical Model Review. **Update: December 2020** This agenda has been developed throughout the incident command structure period, with strengthening of layers of leadership. Key learning has been taken and progressed through to interim management structure. **Update: April 2021** Review of digital means of connection under development with software procured. Training and development to be progressed for rollout

						Update December 2021: Directors schedule on site is produced weekly ensuring on site presence rather than digital links. Directors lead on engagement with teams to ensure visibility. Hospital events not being taken forward face to face so remainder of action ON HOLD. **Update April 2022:** Structured engagement more firmly embedded through development of planning leadership and key workstreams – for Remobilisation Planning, Clinical Model Implementation. Board to consider if new management structure aligned to CMT, is now supporting means and route for engagement, and that reporting will come to the Board in these areas through its workplan. **Board agreed this position in relation to structured engagement/reporting and that this action should be closed on the plan. Completed.**
		Senior Team / RMO presence at key events in hospital calendar e.g. patient learning awards/ sportsman dinner. Promote this through management structures.	CEO / Medical Director	CMT	New: **Review April 2022**	**Update: December 2019** Coordination of central diary of events to help facilitate attendance. **Paused due to Covid-19** **Update August 2021:** Covid restrictions depending event planning through hybrid of in person and digital means with coordination of diary to be led through Corporate Services Team and in place for October 2021. **Update December 2021:** Hospital events not being taken forward face to face. Digital

						platform for Staff Awards. Remainder of action ON HOLD. **Update April 2022:** Ability to take forward on site events is under remit of CMT given the need to coordinate across site in line with national recovery. **Board agreed that this is embedded and can be included as part of CMT workplan and closed as action for this plan. Completed.**
		Link in with Scottish Government once appointment of the Independent National Whistleblowing Officer and Board Champion has been appointed.	Change to Interim HR Director	Board	March 2021	**Completed**
		Plan a schedule of Non-Executive Director informal visits across TSH to help promote the values and behaviours of the organisation.	Chair	Board	New: **Update to Board December 2021**	**February 2020** - Schedule in place for patient and staff engagement with NXD attendance at PPG meetings. **Paused due to Covid-19** **Update: December 2020** Restart may be possible in 2021. PPG meetings have, in part re-commenced virtually, explore possibility of NXD attendance at these meeting virtually. Digital agenda being progressed including online staff engagement for Exec Team. This should be progressed to include NXDs. **Update April 2021:** PPG meetings taking place in person for ID population, and new video conferencing

						equipment under procurement for wider patient group. Non- Executive attendance to be kept under review for 2021 when possible. **Update August 2021:** Covid restrictions depending, non –executive presence on site now being taken forward as per hybrid model of engagement. Workplan Including PPG/ Leadership Walkrounds planned for October 2021 onwards. Link to hospital events such as staff awards through digital means. **Update December 2021:** PPG link and meeting schedule /Patent Safety Walkrounds schedule established (depending on any future restrictions). Link to Staff awards available to Non Execs. **Update April 2022**: Schedule now in place and commenced in February 2022. **Board agreed programme in place and can be closed as part of this plan. Completed.**
ENGAGING STAKEHOLDERS		Review and develop the Communications Strategy to include proactive engagement with aim of addressing dissonance between strategic aims of the hospital and public perception of these aims.	CEO	Board	New: **Roll out over June to December 2021**	**December 2019 -** Review of media strategy in progress with regular updates to the Board. **Update: December 2020** Presentation to Board seminar November 2020, and re-engagement of workstream at start of 2021. **Update April 2021-** Work being progressed January to June 2021 in preparation for roll out. **Update December 2021:** Presentation by Head of Communications to Board.

						Update April 2022: Roll out of Presentations highlighting work of TSH during March 2022, released on YouTube and promoted through social media platforms. Re-start of progress on communications options appraisal exercise following paused due to incident command, and Board reporting in April 22. **Update August 2022:** Board agreed to service transformation workstream in June 2022, with work progressed on website development, as well as recruitment of two further positions in communications team. Board will receive dedicated progress reporting at every second Board meeting going forward, and this is built into workplan. Board to consider closing this item on this plan given stand up of regular and dedicated reporting. **Agreed Closed**

Updated 02.12.22 - M Smith

Paper No. 22/120

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 December 2022
Agenda Reference:	Item No: 21
Sponsoring Director:	Chief Executive
Author(s):	Board Secretary
Title of Report:	Board Workplan 2023
Purpose of Report:	For Decision

1 SITUATION

The Board requires to review its workplan for the coming year to identify the key considerations and actions required during 2022, and to provide assurance on planned areas of reporting.

2 BACKGROUND

The Board considers and approves a workplan annually, and the Board Secretary will support the Board by ensuring that each component part of the workplan is allocated to meeting(s) throughout the year.

3 ASSESSMENT

The workplan has been developed to encompass the key focus areas for the Board in the coming year, and is enclosed at **Appendix A**.

There is a focus on key workstreams, with the implementation of the new Clinical Model reporting to the first two meetings of the year, and monitoring and review assessment of how the model impacts care delivery at the August meeting. Patients' Physical Health will continue to be area for improvement in performance and the Supporting Healthy Choices project will formally report to the Board twice within the year.

Quality and Safety Walkrounds are now firmly embedded into practice, and reporting from these will be included in the regular Quality Assurance and Quality Improvement report at each meeting.

It is expected that the NHS Scotland wide plan, with planning guidance documents, will be issued to NHS Boards by Scottish Government in February 2023 to inform planning in the short, medium and longer term. NHS Boards will be asked to roll forward their existing 2022/23 plans into the first quarter of 2023/24, and then prepare a 12 month operational plan for July 2023 to June 2024.

Reporting to the Board is planned to align with this. The three year Workforce Plan is to be reviewed annually, and the workplan reflects this timeframe to ensure Board oversight. Safe Staffing reporting has been added to commence in the first quarter of 2023/24 pending any further national guidance in this respect.

The Perimeter Security and Enhanced Internal Security Systems Project is expected to be completed within the 2022/23 financial year, and a final scheduled report to come to the Board at its April meeting. The modifications to the Family Centre to support the centralised visiting model are also scheduled to be completed within the current financial year, and therefore a final report on the changes will be presented to the April Board meeting, and an opportunity to monitor and review the impact of the changes at the August meeting.

Climate Change and Sustainability reporting will be formally reported twice a year, subject to further national guidance on the timing of annual reporting.

Development of the Communications function is also a key area of focus and reporting will continue to every second meeting. Similarly, the digital inclusion agenda continues to develop and formal reporting will come to the Board twice a year.

4 RECOMMENDATION

The Board is asked to:

- Review the revised workplan and discuss whether this provides a robust structure for the consideration and scrutiny of the Board's business in 2023, advising whether any change or addition is required.

- Approve the plan as a basis for managing Board business in 2023.

Author:
Margaret Smith
Board Secretary
01555 842012

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Paper No. 22/120

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	To support the Board's Corporate Objectives and strengthen reporting to and oversight by the NHS Board
Workforce Implications	There are no implications as a result of this report
Financial Implications	There are no impacts to consider.
Route To Board Which groups were involved in contributing to the paper and recommendations.	Requested by the Board as part of workplan, and directed through the Corporate Management Team.
Risk Assessment (Outline any significant risks and associated mitigation)	The workplan is developed to provide assurance to the Board, and there are no additional risks to consider
Assessment of Impact on Stakeholder Experience	This is considered by the Board in setting its workplan
Equality Impact Assessment	Not required
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	Not relevant
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One X There are no privacy implications. □ There are privacy implications, but full DPIA not needed □ There are privacy implications , full DPIA included.

THE STATE HOSPITALS BOARD FOR SCOTLAND: BOARD BUSINESS 2023

February 2023	April 2023	June 2023	August 2023	October 2023	December 2023
• Board Minute and Actions • Chair's Report • CEO Report	• Board Minute and Actions • Chair's Report • CEO Report	• Board Minute and Actions • Chair's Report • CEO Report	• Board Minute and Actions • Chair's Report • CEO Report	• Board Minute and Actions • Chair's Report • CEO Report • Annual Schedule of Board/Committee meetings	• Board Minute and Actions • Chair's Report • CEO Report
• Governance Committee Minutes • Clinical Forum Minutes	• Governance Committee Minutes • Clinical Forum Minutes • Corporate Governance Update • Annual Review Feedback (2021/22)	• Governance Committee Minutes • Clinical Forum Minutes • Governance Committee Annual Reports	• Governance Committee Minutes • Clinical Forum Minutes • Corporate Governance Update	• Governance Committee Minutes • Clinical Forum Minutes	• Governance Committee Minutes • Clinical Forum Minutes • Corporate Governance Update
• Corporate Risk Register • Infection Prevention and Control • Bed Capacity	• Corporate Risk Register • Infection Prevention and Control • Bed Capacity	• Corporate Risk Register • Infection Prevention and Control • Bed Capacity	• Corporate Risk Register • Infection Prevention and Control • Bed Capacity	• Corporate Risk Register • Infection Prevention and Control • Bed Capacity	• Corporate Risk Register • Infection Prevention and Control • Bed Capacity

February 2023	April 2023	June 2023	August 2023	October 2023	December 2023
• Clinical Model Implementation • Supporting Health Choices Programme • Quality Assurance and Improvement	• Clinical Model Implementation and Review • Patient, Carer & Volunteer Stories • Nurse and AHP Revalidation Report • Quality Assurance and Improvement	• Clinical Model - Review • Quality Assurance and Improvement	• Patient, Carer and Volunteer Stories • Supporting Healthy Choices Programme • Implementation of Specified Persons Annual Report • Quality Assurance and Improvement	• Clinical Model – Review • Medical Appraisal and Revalidation Annual Report • Medical Education Report • Quality Assurance and Improvement	• Patient, Carer and Volunteer Stories • Patient Advocacy Annual Report • Quality Assurance and Improvement
• Workforce Report • iMatter Update • Whistleblowing Quarter 3 Report	• Workforce Report • Wellbeing Strategy • Whistleblowing Quarter 4 Report • Staff Wellbeing Report • Safe Staffing Report	• Workforce Report • Workforce Plan 2022/25 – Annual Review • Staff Wellbeing • Safe Staffing Report	• Workforce Report • Safe Staffing Report • Whistleblowing Quarter 1 Report	• Workforce Report • Safe Staffing Report • Staff Wellbeing Report	• Workforce Report • Safe Staffing Report • Whistleblowing Quarter 2 report and Annual Statement

February 2023	April 2023	June 2023	August 2023	October 2023	December 2023
• Finance Report • Corporate Objectives 2022/23 • Performance Report Quarter 3 • Security Project • Communications Update	• Finance Report • Annual Review of Standing Documentation • Security Project • Digital Strategy Update • Sustainable Centralised Visiting • Climate Change and Sustainability Report • Update on Planning Cycle	• Finance Report • Annual Accounts • Performance Annual Report • PAMS Submission • Risk and Resilience Annual Report • Communications Update • Board Plan 23/24 – Update	• Finance Report • Performance Report Quarter 1 • Complaints Annual Report • Sustainable Centralised Visiting – Review • Board Plan 23/24 – finalisation	• Finance Report • Communications Annual Report and Update • Information Governance Annual Report • eHealth Annual Report • Digital Strategy Update • Climate Change and Sustainability Report	• Finance Report • Performance Report Quarter 2 • Corporate Risk Register • Visiting Centre Update

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 December 2022
Agenda Reference:	Item No: 22
Sponsoring Director:	Finance and eHealth Director
Author(s):	Deputy Director of Finance
Title of Report:	Financial Position as at 30 November 2022
Purpose of Report:	For Noting

1 SITUATION

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

2 BACKGROUND

2.1 TSH

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

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

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

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

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

2.2 SG Communication

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

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

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

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

3 ASSESSMENT

3.1 Revenue Resource Limit Outturn

The annual budget of £41.008m is primarily the forecast Scottish Government Revenue Resource Limit core and non-core allocations, and anticipated additional allocations (currently £0.261m).

The Board is reporting an underspend of £0.061m to November 2022; with revenue forecast trajectory variance set at £0.050m underspend. The small adverse variance in month is mainly due to reduced ECP patients income (no ECP patients on site to be billed in that month).

PAIAW ("Payment as if at work") funding continues to be held as a reserve for the current year. This continues to be a significant element for the Board (as it is for a number of other Boards) because of our high levels of overtime and high nursing vacancies. There is a pressure since higher levels have continued and the reserve is light.

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

Additional, at March 2022, some costs of the project works started in 2021/22 re the eRostering project *(see para 3.2)*, M365 licences, and related pressures have been accrued to fund an element of anticipated costs in 2022/23.

3.2 Key financial pressures / potential benefits.

Revenue (RRL): -

Covid-19
As noted above, because of the late advice from SG that Covid would no longer be funded there are some remaining cost pressures which will be managed within Directorates, and which will be regularly monitored. Some new posts may be reviewed for permanency, and a schedule of such posts is being prepared for SG review, further to discussion with SG, Chief Executive and Finance and eHealth Director.

eRostering Project
While provision has been noted for the contractual implementation costs of the eRostering project in 2022/23, this project is now being rescheduled nationally by NSS to implement across 2023/24 and 2024/25. Additionally, currently unfunded are the additional posts expected to be required in order to manage this implementation – being three posts requiring an annual funding of approx.£150k. This pressure has been highlighted to SG, and as it is an issue shared by a number of Boards this has been raised by TSH at both DoF and Chief Exec levels as the project is receiving national attention re confirmation of amended timeframes – responses to this issue are awaited.

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

Energy and inflation increases
The rising costs of energy supplies and the knock-on effect on other supply chain deliverables will be closely monitored in 2022/23 as it is expected that there could be significant pressure in 2023/24.

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

Benefits
Travel underspend has continued through the year and ongoing budgets will be amended accordingly to reflect changed ways of working. There are also some divisional training underspends noted in-year.

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

Directorates	Annual Budget £'k	Year to Date Budget £'k	Year to date Actuals £'k	YTD Variance (budget less actuals) for period 8	Budget WTE	Actual WTE
Nursing And Ahp's	22,432	15,093	15,008	84	402.10	413.47
Security And Facilities	6,555	4,387	4,475	(88)	121.62	116.45
Medical	3,040	1,998	1,885	113	20.55	21.05
Chief Exec	2,041	1,355	1,323	32	22.96	22.62
Human Resources Directorate	991	661	616	45	15.15	14.57
Finance	2,781	1,855	1,839	16	29.43	31.58
Cap Charges	2,641	1,761	1,753	7	0.00	
Misc Income	(600)	(400)	(372)	(28)	0.00	0.00
Central Reserves	1,126	54	174	(120)	0.00	0.00
	41,008	**26,762**	**26,702**	**61**	**611.81**	**619.74**

Nursing – Includes Ward Nursing overtime pressure, and there will be benefit from leavers being replaced by new starts in year which will contribute to the underachieved savings, plus offset with vacancies in other departments which gives a net underspend position.

Security & Facilities – Biomass and electricity overspends are noted, with a focus forward on monitoring energy costs in a pressured market. There are remaining covid pressures for disposable items being used for patient food delivery, and food price increases are also causing pressure in the kitchen and staff restaurant. Pressures are also noted regarding essential Estates repairs and laundry.

Medical – Some Medical recharges have now ceased resulting in an adverse effect, being offset with post vacancies, underspends in non-pay, and research underspend to date. Pharmacy savings are currently under achieved.

CE – Non-pay expenditure underspends noted.

HR – Vacancy benefits have to date countered staff cost pressures, with benefit noted also from corporate training underspend.

Finance – eHealth cost pressures are noted, with review undertaken of utilisation/allocation of non-recurring strategic funding received.

Capital Charges – We are awaiting SG confirmation of the required change to the allocation (core to non-core adjustment) – £2.620m being the estimate, with AME provision currently set at 21/22 value.

Miscellaneous Income (MI) – The budget recognises income billed for exceptional circumstance patients, with appropriate provision for boards with whom recoverable balances are being discussed. Currently (Nov) there are no ECP patients at TSH.

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

Some of the anticipated RRL confirmations are awaited for final confirmation in months 9-12.

4 ASSESSMENT – SAVINGS

The following table summarises the savings set by Directorate.

Cumulative Savings	Savings - Annual Target	Achieved to date / post base adj'ts	(Still to be achieved) / over achieved
Directorate	**£'k**	**£'k**	**£'k**
Chief Executive	(41)	0	(41)
Finance	(42)	13	(29)
Nursing & AHP's	(347)	345	(2)
Human Resources	(29)	0	(29)
Medical	(68)	25	(43)
Security & Facilities	(115)	75	(40)
Unidentified (phased ytd) - so all 'achieved'	(169)	0	(169)
Total	**(811)**	**458**	**(353)**

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

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

All the savings achieved to date are from vacancies in various Directorates, mainly Psychology and Housekeeping.

National Boards Contribution

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

5 CAPITAL RESOURCE LIMIT

The recurring capital allocation anticipated from Scottish Government for 2022/23 is £0.269m. Additionally, we have a carry forward of unspent 2021/22 allocated project funding for Key Safes & MSRs – this £0.605m was included in our August Allocation schedule – for which work is well underway and completion expected within 2022/23.

In addition, funding has been applied for and received in-year to support backlog maintenance work required on the Hospital site – a range of Estates and Security work was identified and these areas of work are all now included in the planned programme for the current year. A small element of this is revenue work, for which confirmation is awaited by 'SG'.

With regard to the Perimeter Security Project allocation, there are elements of unforeseen delays in the project – now likely to be completing in early 2023 (Q1) – requiring carry forward of unspent monies from 2021/22.

Payment to the contractor has been negated in recent months due to offset with penalties.

CAPITAL CRL 2022/2023 AS AT NOVEMBER 2022	ANNUAL PLAN £'k	YTD PLAN £'k	YTD SPEND £'k	under/ (over) £'k
PERIMETER SECURITY				
STANLEY SECURITY SOLUTIONS LTD		157	157	0
THOMSON GRAY LTD		129	129	0
TSH STAFFING APR - SEP'22		129	129	0
DJ GOODE		0	0	0
PERIMETER SECURITY TOTAL (Yr 2 of 2)	905	415	415	0
CAPITAL				
IM&T	17	13	13	0
OTHER	252	64	64	0
MSR refurbishment	400	0	0	0
Family Centre gardens	0	87	87	0
Key-safes refurbishment	205	0	0	0
CAPITAL	874	164	164	0
Total CRL	1,779	579	579	0

6 RECOMMENDATION

Revenue

The year to date position is £0.061m underspend, with breakeven anticipated for the year-end.

Capital

CRL June 2022 received £0.874m, with the specific perimeter allocation awaited with the confirmation of the final 2022/23 balance required. It is anticipated that our capital allocation will be fully utilised in-year.

The Board and Scottish Government are asked to note the content of this report.

MONITORING FORM

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

Paper No. 22/122

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 December 2022
Agenda Reference:	Item No: 23
Sponsoring Director:	Chief Executive
Author:	Head of Corporate Planning and Perfromance Clinical Effectiveness Team Leader Corporate Planning and Risk Project Support Officer
Title of Report:	Performance Report Q2 2022/2023
Purpose of Report:	For Noting

1. SITUATION

This report presents a high-level summary of organisational performance through the reporting of Key Performance Indicators (KPI's) for Q2: July - September 2022. Trend data is also provided to enable comparison with previous performance. The national standards directly relevant to the State Hospital are as follows: Psychological Therapies Waiting Times and Sickness Absence. Additional local Key Performance Indicators (KPIs) are reported to the Board and included in this report. Board planning and performance are monitored by Scottish Government through the Annual Operational Plan for 2022-23 which was submitted to Scottish Government to outline the priority areas of development.

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

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

2. BACKGROUND

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

The calculation for a quarterly figure is an average of all three month's totals.

3. ASSESSMENT

The following sections contain the KPI data for Q2 and highlight any areas for improvement in the next quarter through a deep dive analysis for KPI's that have miss their targets.

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

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

- Patients have their care and treatment plans reviewed at 6 monthly intervals.
- Patients will have a healthier BMI.
- Sickness absence rate (National HEAT standard is 4%).

Performance Indicator	Target	RAG Q3 21/22	RAG Q4 21/22	RAG Q1 22/23	RAG Q2 22/23	Actual	Comment
Patients have their care and treatment plans reviewed at 6 monthly intervals	100%	A	A	A	R	89.36%	This indicator moves into the red zone for Q2.
Patients will be engaged in psychological treatment	85%	G	G	G	G	85.00%	This indicator remains green for this quarter.
Patients will be engaged in off-hub activity centers during COVID-19	90%	G	G	G	G	91%	This figure includes drop-in sessions, which took place in hubs, grounds and the Skye Centre.
Patients will undertake an annual physical health review	100%	-	-	G	G	100%	100% compliance. Green compliance for this amended KPI.
Patients will undertake 150 minutes of exercise each week	60%	-	-	G	G	70.40%	Green zone for this KPI's data collection.
Patients will have a healthier BMI	25%	R	R	R	R	9%	This indicator has remained in the red zone this quarter.
Sickness absence rate (National HEAT standard is 4%)	** 5%	R	A	G	R	8.39%	July's figure was 6.81%, August's figure was 8.42% and September's figure was 9.95%.
Staff have an approved PDR	*80%	G	G	G	G	83.20%	This indicator has been within the green zone since March 2019.
Patients transferred/discharged using CPA	100%	G	G	G	G	100%	6 patients were transferred during this quarter all using CPA.
Patients requiring primary care services will have access within 48 hours	*100%	G	G	G	G	100%	This indicator remains 100% in Q2.
Patients will commence psychological therapies <18 weeks from referral date	**100%	A	A	A	G	96.10%	3 instances of patients waiting beyond the specified wait time during Q2.
Patients have their clinical risk assessment reviewed annually.	100%	G	A	G	G	95.66%	As at 30 September 2022, there were 111 patients in the hospital. Ten were new admissions and five patients had an out of date risk assessment.
Attendance at CPA Reviews (Refer to Appendix 1)							

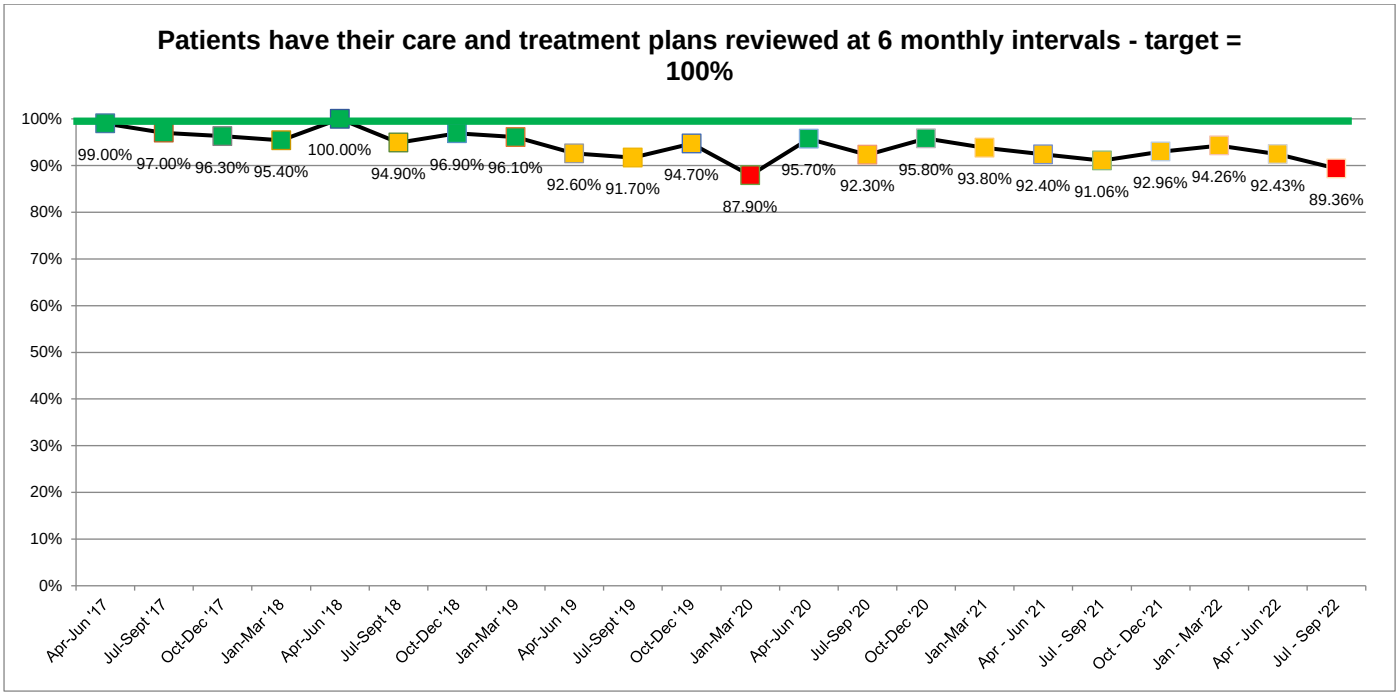
No 1: Patients Have their Care and Treatment Plans Reviewed at 6 Monthly Intervals

Target: 100%

Data for current quarter: 89.36%

Performance Zone: Red

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



This data is reviewed monthly with the quarterly KPI taking an average across the three months in the quarter. In July, the compliance was 84.2%, August was 87.9% and September was 96% giving a quarterly compliance of 89.36%, which is a slight decrease from last quarter's figure. This indicator now moves into the red zone.

On 30 September 2022, there were 111 patients in the hospital. Ten of these patients were in the admission phase. Four CPA documents had not been reviewed within the 6-month period, or within the agreed admission phase. Three of these CPAs have been held with no documents being uploaded to RiO within allocated timescales. The other one is scheduled to take place more than 6 months after the previous CPA being held or an admission CPA held over 4 months after the date admitted.

A review into the data showed that from 1 January 2022 to 30 September 2022, the average number of days patients waited beyond their target timeline for their CPA to be held was 39 days, with the medium number being 35 days over the target timeline.

Work has continued to be undertaken to ensure continuous improvement in this KPI. The Health Records Manager has provided rolling monthly updates to all relevant individuals as requested and support is continually offered to all secretaries regarding the uploading of these documents onto RiO within the allocated timescales. Health Records staff continue to send reminder emails to RMOs and medical secretarial staff to advise that a patient's review or renewal of detention is due. The renewal of detention ties in with the annual CPA document being completed.

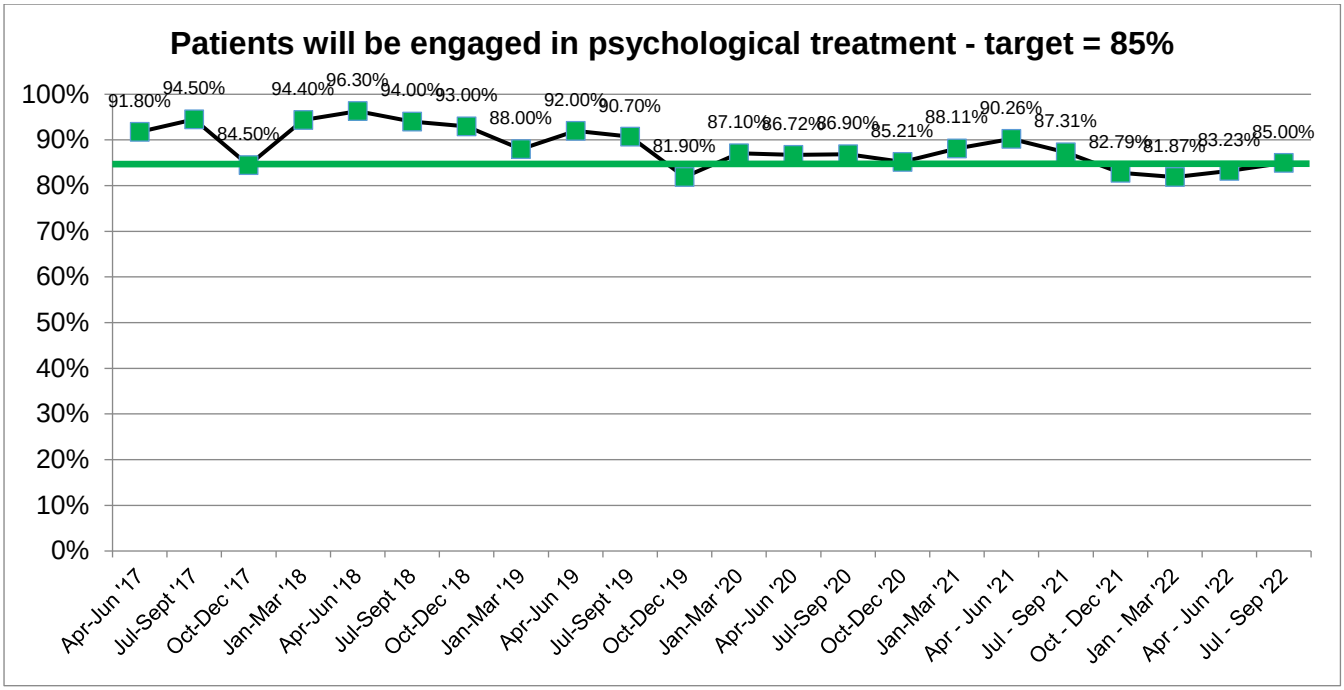
No 2: Patients will be Engaged in Psychological Treatment

Target: 85%

Data for current quarter: 85%

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.



This data is reviewed monthly with the quarterly KPI taking an average across the three months in the quarter. In July, the compliance was 80.35%, August was 87.38% and September was 87.27% giving a quarterly compliance of 85%, which is a slight increase from last quarter's figure. This indicator remains with the green zone.

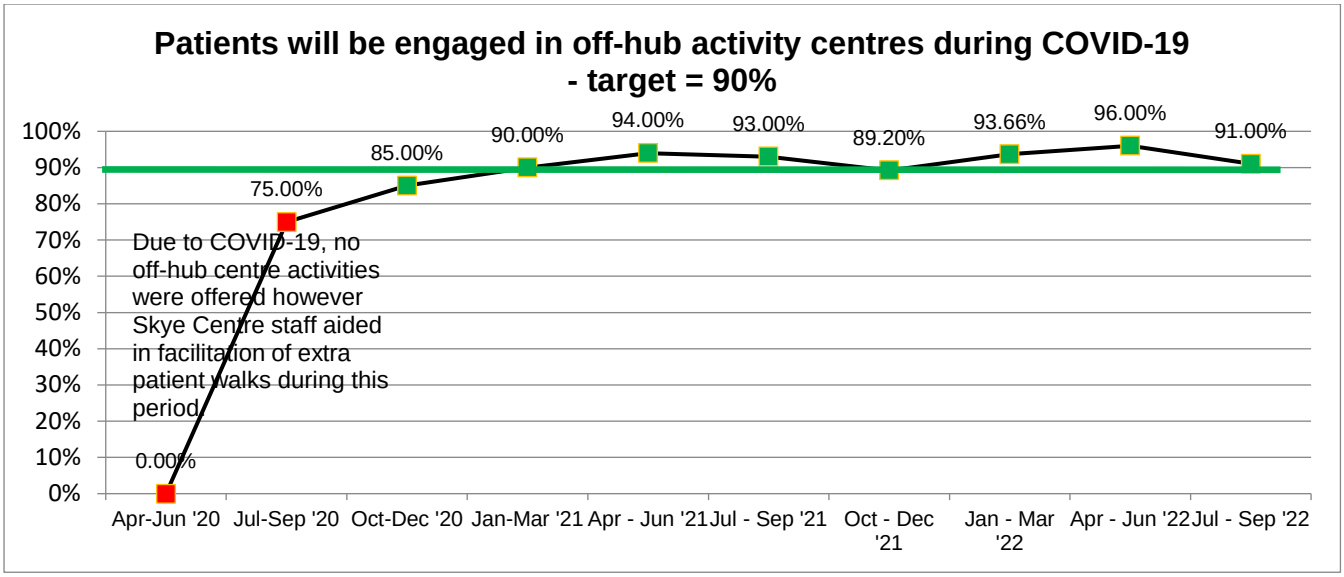
No 3.1: Patients will be Engaged in Off-Hub Activity Centers during COVID-19

Target: 90%

Data for current quarter: 91%

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 indicator includes data gathered pertaining to scheduled activity in addition to all off-ward drop-in activity rates at the Skye Centre from July 2020 onwards.

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

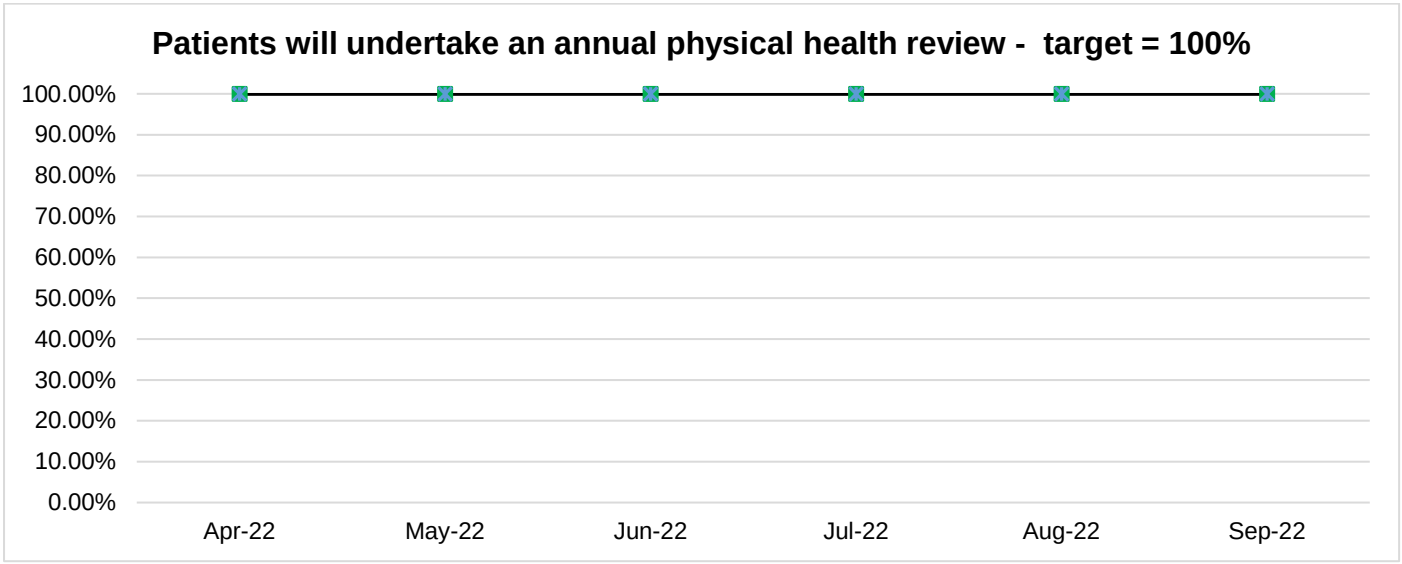
No 4: Patients will Undertake an Annual Physical Health Overview

Target: 100%

Data for current quarter: 100%

Performance Zone: Green

This indicator is linked to the National Health and Social Care Standards produced by Healthcare Improvement Scotland (HIS). The indicator measures the uptake of the annual physical health review. The target has been increased to 100% from the 90% target before to recognize that the Annual Physical Health Overviews should be carried out for every patient every year.



As at 1 April 2022, this KPI was amended to incorporate the uptake of an annual physical health review by all of our patients, rather than the previous data collection of an offering of a review. This KPI now charts the completion of an annual physical health overview by the Practice Nurse. The Practice Nurse then refers appropriate patients on for face

to face review by the GP. The GP conducts these consultations to complete the physical assessment of the annual health review.

During Q2, 100% of patients who were eligible for an annual physical health review were reviewed by the Practice Nurse. Out of these 23, 21 were reviewed in addition by the GP. Two patients did not attend their face-to-face consultations; this was due to one patient suffering from poor mental health and the other patient refusing to attend. Both of these reviews have been rescheduled.

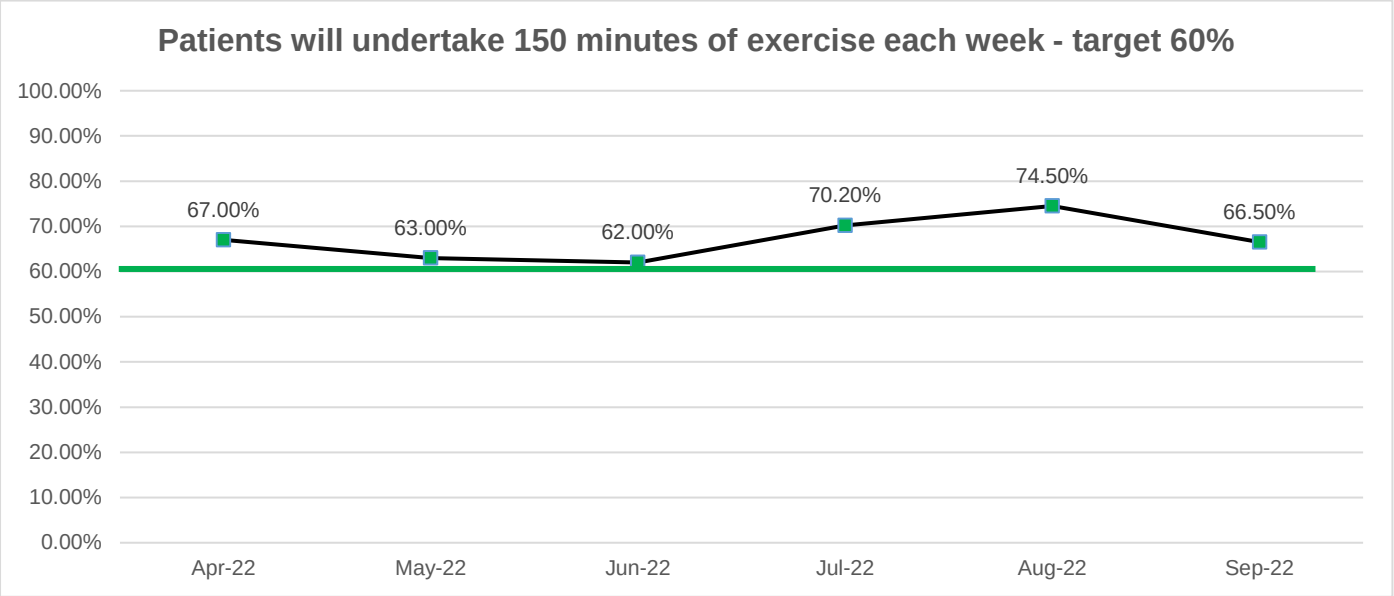
No 5: Patients will be Undertake 150 Minutes of Exercise Each Week

Target: 60%

Data for current quarter: 70.40%

Performance Zone: Green

This links with national activity standards for Scotland. This measures the number of patients who undertake 150 minutes of exercise each week.



At the Board meeting in June 2022, the Board agreed to change the corporate Key Performance Indicator from 80% of patients will achieve 90 minutes of moderate physical activity per week to 60% of patients will achieve 150 minutes of moderate physical activity per week following guidance released by the WHO and reviewed by the PHSG. This change will be effective from 1 April 2022 and will be reviewed after 4 quarters data to assess whether the target should be increased to 70% for 2023/24.

Since the change in KPI on 1 April 2022, the target has been achieved on 17 out of 22 weeks.

This is recorded and calculated when patients participate for more than 10 minutes of moderate activity and does not include patients being escorted / or using grounds access to and from the Skye Centre (unless it has been agreed by the patient's keyworker).

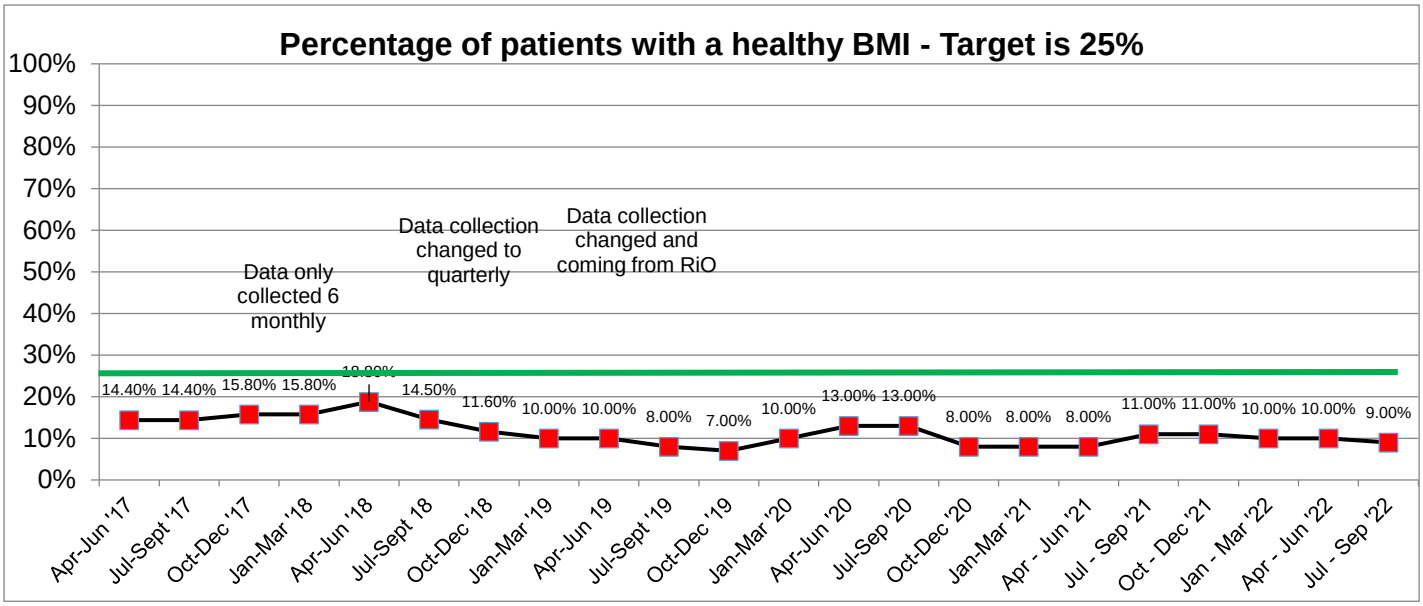
No 6: Patients will have a Healthy BMI

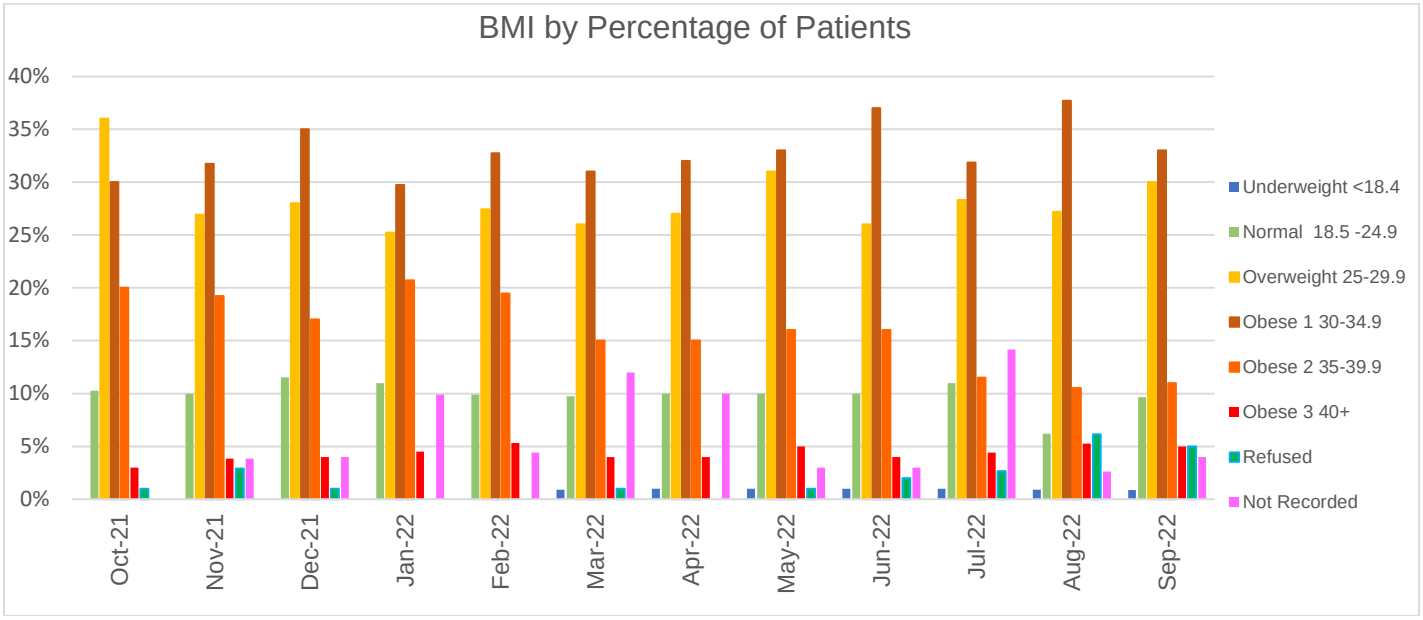
Target: 25%

Data for current quarter: 9%

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 9% of patients have a healthy BMI; this has declined by 1% since the last quarter. This indicator remains in the red zone. The data is a snap shot per month of the population, taken on the 12th of the month.

During this quarter, there was 17 instances where a patient had gained enough weight to move up a weight category and 19 patients who reduced in weight enough to move them down a weight category. Fifteen patients refused to have their weight taken during this quarter and there were 23 instances during this quarter where a patient's weight was not recorded.

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

Weight Range BMI	Q2 Jul-Sep 2022 N=102	Q1 Apr-Jun 2022 N=107	Q4 Jan-Mar 2022 N=98	Q3 Oct-Dec 2021 N=107
<18.5 Underweight	1%	1%	1%	0%
18.5-24.9 Healthy	11%	10%	10%	11%
25-29.9 Overweight	30%	28%	26%	30%
30-34.9 Obese (Class 1)	33%	34%	31%	32%
35-.39.9 Obese (Class 2)	11%	16%	18%	19%
>40 Obese (Class 3)	5%	4%	5%	4%

*N.B. The N number equates to how many patients we hold BMI data for during the last month of the quarter. Missing data relates to those patients who did not have their weight recorded, who refuse a weight check or are too unwell to undertake a BMI check.

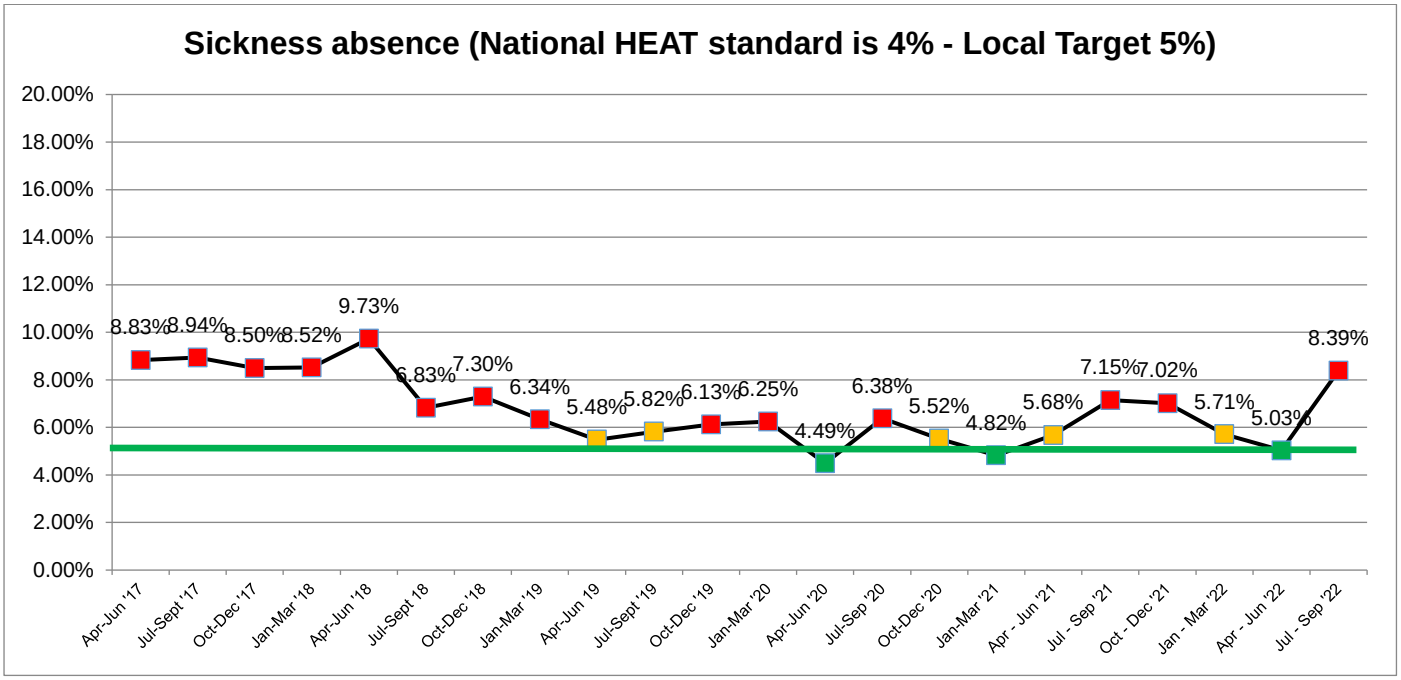
No 7: Sickness Absence (National Heat Standard is 4% - Local Standard Is 5%)

Target: 5%

Data for current quarter: 8.39%

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. The State Hospital uses the data provided from SWISS for this KPI to align with all NHS Scotland Boards to ensure valid comparisons across Scotland can be achieved. The figures provided via SWISS data slightly differ from SSTS figures; this is due to the SWISS contractual hours being averaged over the 12-month period and the figures from SSTS are based on the contractual hours available within that month.



Sickness absence continues to be closely monitored with staff being managed through the formal stages of the Attendance Policy. The key reasons for short term absence are cold, cough, flu, anxiety/stress/depression and back problems. For long term absence, the main reasons are anxiety/stress/depression, other musculoskeletal and back problems. The HR Advisors hold monthly meetings with all departments to look at the staff who have reached trigger points within the Attendance Policy and to ensure that managers address these in line with the policy. The HR team regularly attend the SCN forum providing an opportunity for this group to ask questions on the Attendance Policy and

explore common questions such as timeframes for meetings, monitoring periods and follow up meetings. Attendance management training has also been developed for delivery as part of the Charge Nurse Development Programme. This focuses on key aspects of attendance management that Charge Nurses support including communication during periods of absence and how to complete return to work interviews. Staff Governance Committee has requested that a detailed analysis work be undertaken to consider the any data from Health Boards, learning about any additional support we need to put in place and a further analysis of supporting staff who are on long-term sick leave.

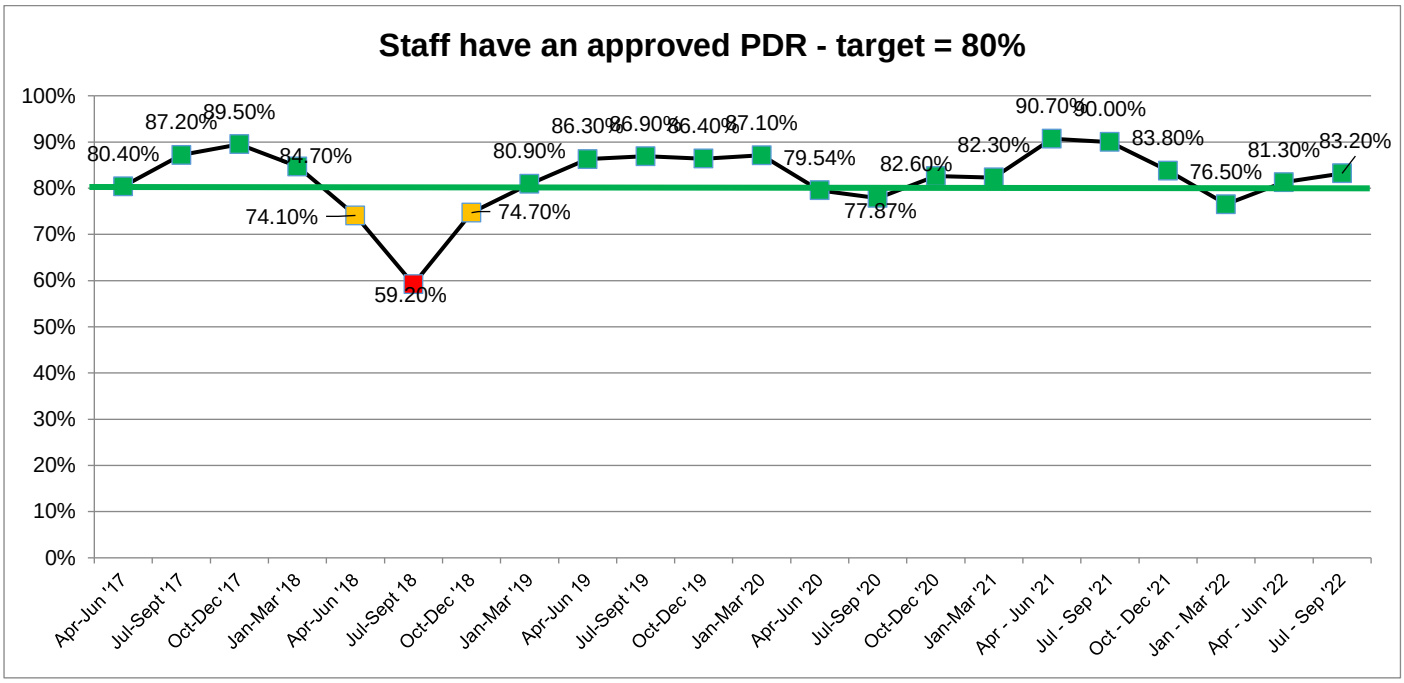
No 8: Staff have an Approved PDR

Target: 80%

Data for current quarter: 83.20%

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.



This data is reviewed monthly with the quarterly KPI taking an average across the three months in the quarter. In July the compliance was 83%, August was 83.3% and September was 83.3% giving a quarterly compliance of 83.2%, which is a slight increase from last quarter's figure. This indicator remains with the green zone.

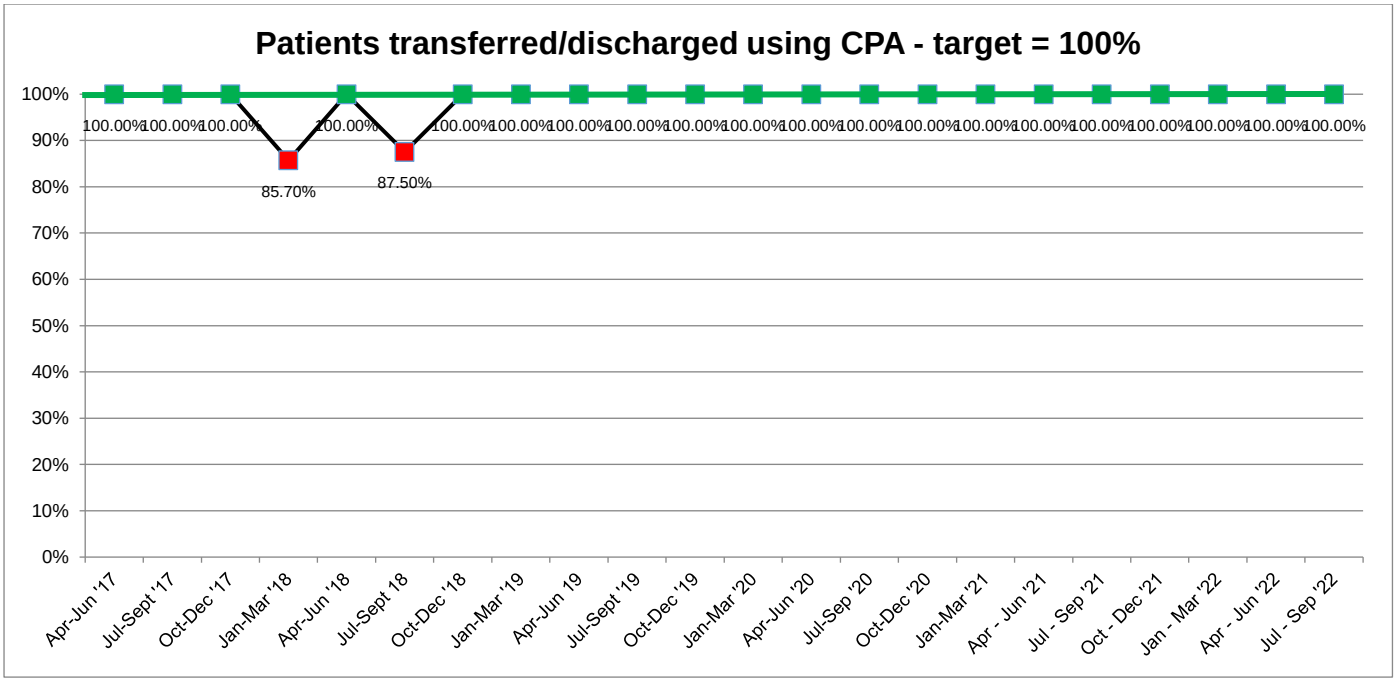
No 9: Patients are Transferred/Discharged using CPA

Target: 100%

Data for current quarter: 100%

Performance Zone: Green

The indicator is linked to the Mental Health Act, 2003 and the streamlining of discharges and transfers. The number of patients transferred out using CPA process are measured through this indicator.



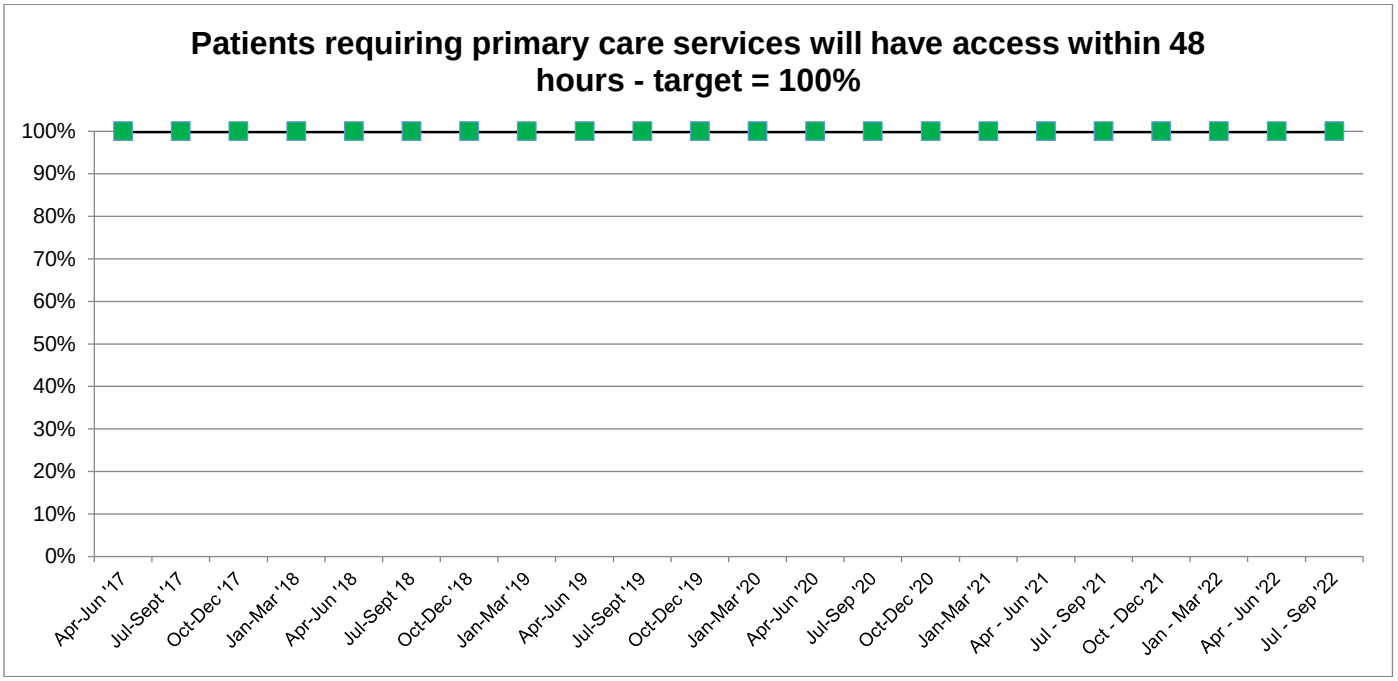
No 10: Patients Requiring Primary Care Services Will Have Access within 48 Hours

Target: 100%

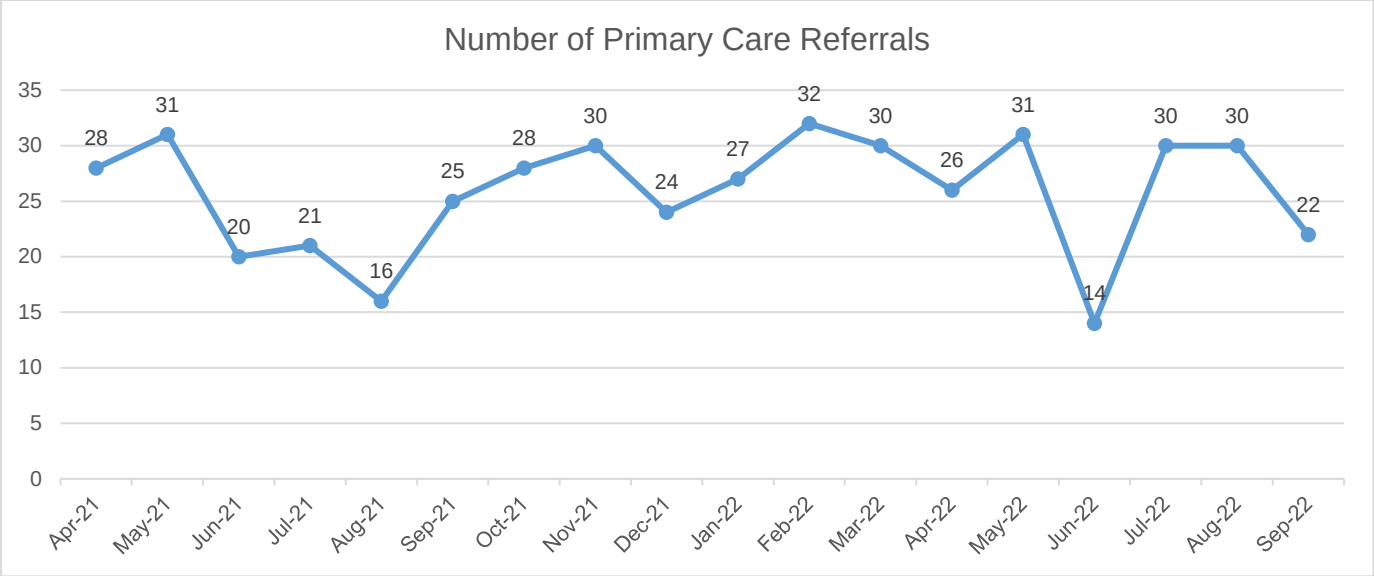
Data for current quarter: 100%

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.



All referrals made to the Health Centre have been actioned within 48 hours. The referrals are triaged when received and onward referral to the most appropriate specialist. These have been actioned by a range of practitioners, including the GP who attends for 2 sessions per week and the Practice Nurse.



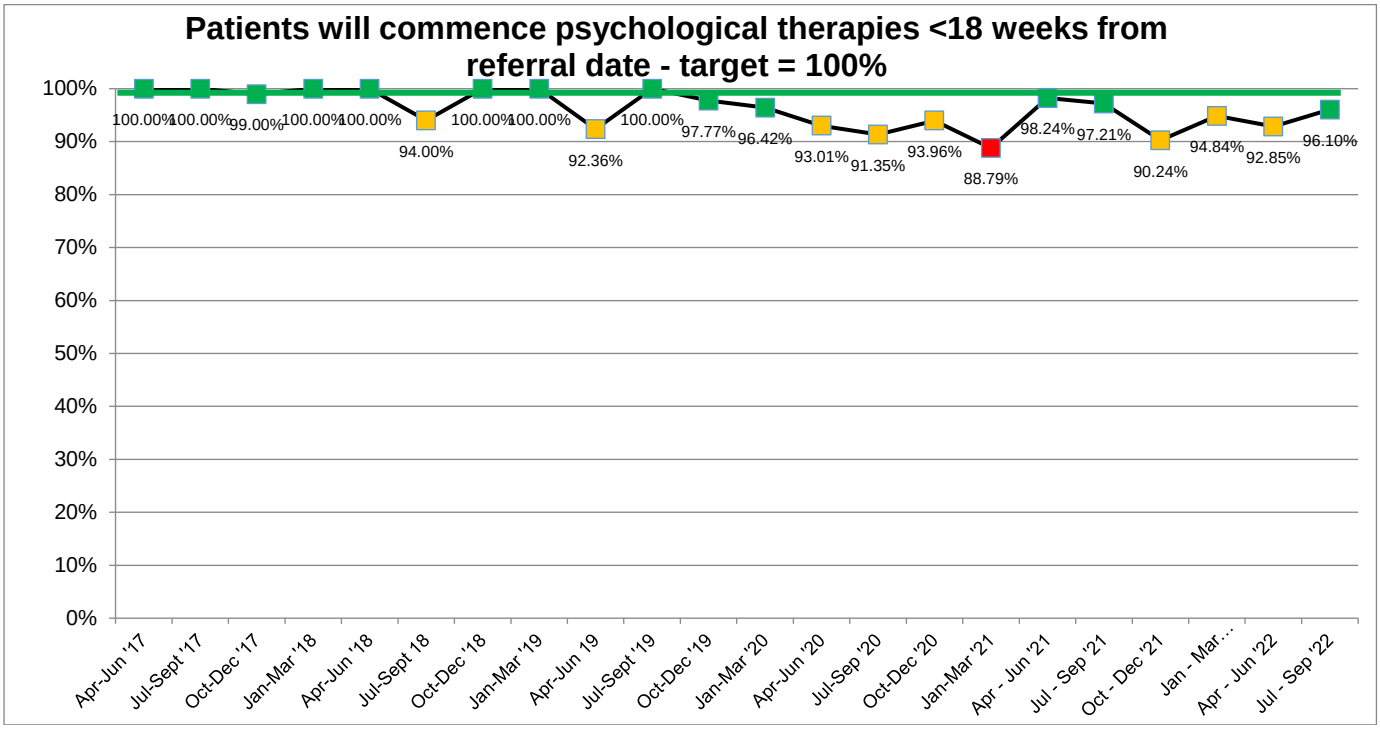
No 11: Patients will Commence Psychological Therapies <18 Weeks from Referral Date

Target: 100%

Data for current quarter: 96.10%

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. The data required for this calculation are the number of patients waiting to engage in a psychological intervention to which they were referred who has not already completed another psychological intervention whilst waiting.



The calculation for this KPI was revisited due to an inconsistency in the figures and all data points have been updated. During Q2, three patients waited beyond the expected referral timeframe to commence their psychological therapies. All patients who are waiting for a therapy should still have regular contact with their psychology team and during their pre-CPA interviews.

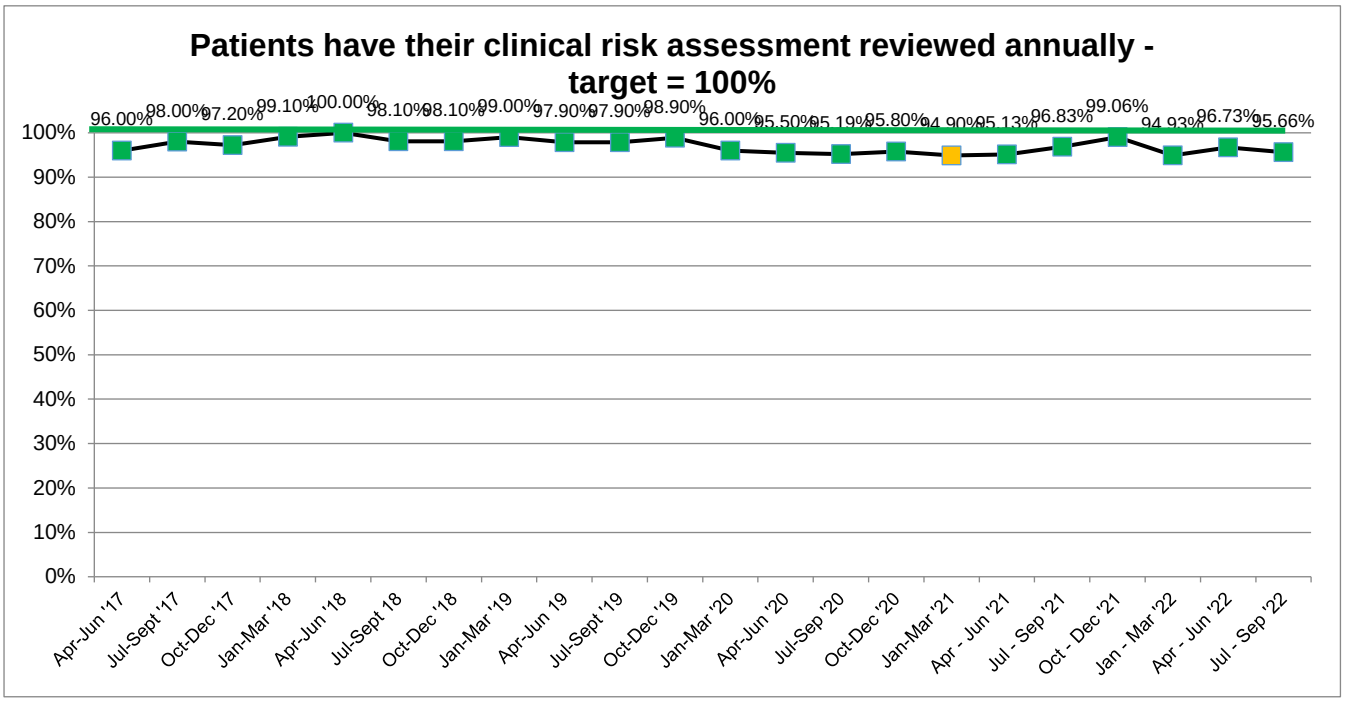
No 13: Patients have their Clinical Risk Assessment Reviewed Annually

Target: 100%

Data for current quarter: 95.66%

Performance Zone: Green

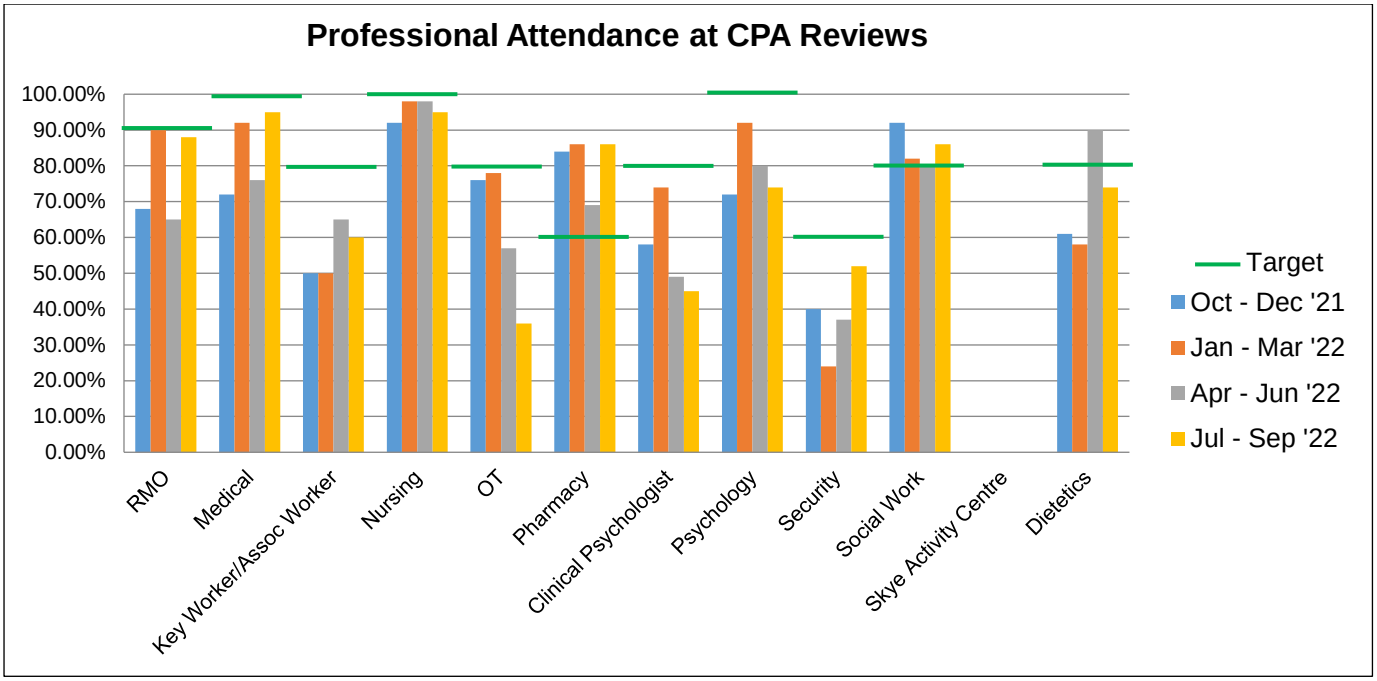
The indicator links with the Mental Health Care and Treatment Act Scotland, 2003. Examples of clinical risk assessments would be a HCR20 / SARA.



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.



Profession	Target	July 22 n=12	Aug 22 n=13	Sept 22 n=17
RMO	90%	88%	85%	88%
Medical	100%	100%	85%	100%
KW/AW	80%	60%	55%	59%
Nursing	100%	100%	92%	94%
OT	80%	36%	15%	35%
Pharmacy	60%	86%	100%	82%
Psychologist	80%	45%	62%	47%
Psychology	100%	67%	85%	71%
Security	60%	52%	46%	65%
Social Work	80%	86%	85%	100%
Skye Centre	tbc	0%	0%	0%
Dietetics	80%	74%	67%	80%

The targets for attendance are set to reflect what is reasonable to expect from each discipline and have been in place for over 5 years. Attendance at case reviews was recorded as both physical and virtual attendance.

RMO – attendance for this profession has increased to 68% in Q2. This indicator moves into the green zone for this quarter.

Medical – this profession moves in the green zone for this quarter, with an increase from 76% to 95% in Q2.

Key Worker/Associate Worker – attendance figures decreased to 60% for this quarter. On the 15 occasions where a key worker / associate worker was unable to attend the CPA, a nursing representative attended in their place.

Nursing – during Q2, nursing attendance slightly decreased to 95%; this profession remains in the green zone.

OT – attendance has decreased during Q2 to 36% from 57%. OT has therefore remains into the red zone for this quarter. This can be mainly attributed to staff sickness and staff vacancies within this department.

Pharmacy – attendance for this quarter has increased from 69% to 86%. This profession remains within the green zone.

Clinical Psychologists – this profession's attendance has declined in Q2 to 45%. This indicator remains in the red zone. Eleven instances where the VAT form was not completed and a combination of annual leave, no reason, staff sick leave and staff vacancy made up this percentage.

Psychology – this professions attendance has decreased in Q2 to 74%. This profession moves into the red zone. On 12 occasions where the Psychologist was unable to attend, a Psychology representative attended in their place.

Security - attendance from security has increased in this quarter from 37% to 52%. Security moves into the amber zone for this quarter. This can be attributed to staff annual leave and staff off duty.

Social Work – attendance has slightly increased in Q2 to 88% from 80%. This profession remains in the green zone.

Dietetics – during Q2, attendance from dietetics has decreased to 74% from 90% in Q1. This professions moves into the amber zone. This can be attributed to staff annual leave, admin error, no reason given, staff off duty and the VAT not being completed.

4. RECOMMENDATION

The Board is asked to **note** the contents of this report.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Monitoring of Key Performance Indicator Performance in the TSH Local Delivery Plan (2017-2020), the Operational Plan and the Remobilisation Plan submitted to Scottish Government in September, to cover the period September 20 – March 21.
Workforce Implications	No workforce implications - for information only.
Financial Implications	No financial implications - for information only.
Route to Board Which groups were involved in contributing to the paper and recommendations?	Corporate Management Team
Risk Assessment (Outline any significant risks and associated mitigation)	There is a dependency on the Business Intelligence project. While we can identify other ways of obtaining and analysing data there will be continue to be limitations on the timeliness and granularity of the information reported.
Assessment of Impact on Stakeholder Experience	The gaps in KPI data which make it difficult to assess.
Equality Impact Assessment	No implications identified.
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	n/a
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One √ There are no privacy implications. □ There are privacy implications, but full DPIA not needed □ There are privacy implications, full DPIA included.

Appendix 1

Item	Code	Principles	Performance Indicator	Profession (Lead)	Target	RAG Q1	RAG Q2	Overall attendance Jul – Sep 2022 (n=42)	Overall attendance Apr – Jun 2022 (n=51)	Overall attendance Jan – Mar 2022 (n=50)	Overall attendance Oct – Dec 2021 (n=50)
15	T	2, 6, 7, 9	Attendance by all clinical staff at case reviews	RMO **(LT)**	90%	R	G	88%	65%	90%	68%
				Medical **(LT)**	100%	R	G	95%	76%	92%	72%
				Key Worker/Assoc Worker **(KM)**	80%	R	R	60%	65%	50%	50%
				Nursing **(KM)**	100%	G	G	95%	98%	98%	92%
				OT**(MR)**	80%	R	R	36%	57%	78%	76%
				Pharmacy **(LT)**	60%	G	G	86%	69%	86%	84%
				Clinical Psychologist **(JM)**	80%	R	R	45%	49%	74%	58%
				Psychology **(JM)**	100%	R	R	74%	80%	92%	72%
				Security **(DW)**	60%	R	A	52%	37%	24%	40%
				Social Work **(KB)**	80%	G	G	86%	80%	82%	92%
				Skye Activity Centre **(KM)** (only attend annual reviews)	tbc			0%	0%	0%	0%
				Dietetics **(KM)** (only attend annual reviews)	80%	G	A	74% (n=19)	90% (n=19)	58% (n=28)	61%

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:	22 December 2022
Agenda Reference:	Item No: 24
Sponsoring Director:	Director of Security, Resilience and Estates
Author(s):	Director of Security, Resilience and Estates
Title of Report:	Sustainable Centralised Visiting modification plan -update
Purpose:	For Noting

1 SITUATION

As part of The State Hospital's (TSH) response to the Covid-19 pandemic, the interim centralised visiting model was implemented in July 2020, using the Family Centre to support prevention and control of infection. The Family Centre was designed to provide a balance between security and child protection and facilitates visits for patients and family with prior approval by the clinical team. Following positive feedback on the interim model a request was made to the Corporate Management Team (CMT) to purpose the centre as the main visiting area for the hospital with visiting for patients with more complex needs continuing to be facilitated within the ward environment.

2 BACKGROUND

Visiting has historically taken place within the ward environment, facilitated by nursing staff. Considerable feedback has been shared by stakeholders indicating that this environment is not always conducive for visits. There have also been numerous requests for access to outdoor space for visiting when weather permits. Additionally, Scottish Government Person Centred Visiting guidance calls for a more tailored approach to meeting individual needs, advocating the need to ensure that visiting environments are fit for purpose and embrace the concept of 'open visiting', which enables family and friends to be more involved in the delivery of care, including spending mealtimes together.

Following the request to CMT to re-purpose the Family Centre, a risk assessment highlighted that additional security control measures would be required to ensure that centre was fit for purpose and all relevant risks had been highlighted and appropriate control measure were in place in line with the hospital's Risk Management Strategy.

The CMT commissioned a short life working group remitted to identify and assess any long term risk in using the Family Centre,as well as maintaining and improving security and defining costings for implementation. The group consisted of:

Responsible Medical Officer (Lead)
Head of Estates and Facilities
Head of Security
Head of Risk and Resilience
Estates Officer
Person Centred Improvement Lead

3 ASSESSMENT

Initial assessment identified adaptations with an estimated cost of £100k, however following a Fire Risk Assessment the security proposal was adapted resulting in a new plan with reduced costs of £75k.

A capital budget has already been allocated to upgrade the Family Centre garden, supporting wider use of the outdoor environment for visiting and this work has been completed.

As previously highlighted, there are a number of security enhancements that require to be implemented to support the new access/egress and management of the area during visits including additional electronic locking mechanisms and CCTV. All orders have been placed for this additional equipment.

The programme of works is on track for completion by 31 March 2023 and is monitored through the Capital Group chaired by the Director of Finance.

4 RECOMMENDATION

The Board are invited to note progress.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Supports delivery of person-centred service delivery objectives.
Workforce Implications	
Financial Implications	Additional budget required for capital costs.
Which groups were involved in contributing to the paper and recommendations.	SLWG, Board requested
Risk Assessment (Outline any significant risks and associated mitigation)	
Assessment of Impact on Stakeholder Experience	Responds to stakeholder feedback reporting improved visiting experience within the Family Centre.
Equality Impact Assessment	Not required. Family Centre more accessible for those with mobility issues.
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do)	No implications.
Data Protection Impact Assessment (DPIA) See IG 16	Tick One **x** There are no privacy implications. ☐ There are privacy implications, but full DPIA not needed ☐ There are privacy implications, full DPIA included

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 December 2022
Agenda Reference:	Item No: 25
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 09th December 2022 and is scheduled to meet again on 19th January 2023.

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

3. ASSESSMENT

a) General Project Update:

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

- Construction Phase – 45% completed (7 work faces in progress, 18 to be commenced)
- Testing and Commissioning – not yet commenced
- Detailed Design Packages – 96% completed
- Construction Health and Safety documentation – 65% completed (14 to be commenced)
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b) Project Timescales & Quality Issues:

Programme revision 41 was accepted with Caveats and an end date of 17 January 2022. Revision 42 was requested due to the changes in scope related to the Fence works. This was produced and rejected due to errors. Revision 43 is in production & is expected before Christmas. Stanley are currently dealing with technical challenges that have led to delay that should be fully quantified in revision 43.

Due to the delay in delivery, the current technical challenges and the approaching critical Site Acceptance Tests, a review of project performance and management has taken place with Stanley's senior management on site. All parties agreed that the current issues require normal commercial constraints that can affect joint working to be put aside whenever possible in order to improve communication and delivery. As a result:

- The Director responsible for the project will attend site at least monthly
- The Director responsible for the project has made more time available for this project
- Increased technical support to the delivery team is to be introduced
- Meetings between Stanley, TSH and Subcontractors will take place when necessary
- Joint programme planning meetings will take place when necessary
- The existing Project meetings structure has been reviewed and refocussed

All quality targets are being met.

c) Finance – Project cost

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

The key project outline is:

Project Start Date:	April 2020
Planned Completion Date:	Jan. 2023
Contract Completion Date:	April 2022
Main Contractor:	Stanley Security Solutions Limited
Lead Advisor:	ThomsonGray
Programme Director:	Doug Irwin
Total Project Cost Projection (including VAT):	£10,452,907
Total costs to date (Inc. VAT) at 12th December 2022:	£ 9,748,502

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

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

Actual spend to date is below the amount forecast by Stanley that would be reflective of their planned schedule of works. As the current packages of works are significant and amounts are due on completion of each package there is a continuing mismatch between work on site and payments made. Recent months have been further complicated by penalties in excess of works completed and amounts due resulting in a nil valuation.

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

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

Stanley	£ 6.843m (5% retention applied)
Thomson Gray	£ 0.810m
Doig & Smith	£ 0.008m
HVM Design	£ 0.017m
VAT	£ 1.536m
Staff Costs	£ 0.535m
	£ 9.749m

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.