THE STATE HOSPITALS BOARD FOR SCOTLAND

BOARD MEETING

THURSDAY 22 JUNE 2023
at 12.30 pm, held on MS Teams
A G E N D A

12.30pm			
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 April 2023	For Approval	TSH(M)23/03
4.	**Matters Arising:**		
	Actions List: Updates	For Noting	Paper No. 23/40
5.	**Chair's Report**	For Noting	Verbal
6.	**Chief Executive Officer's Report**	For Noting	Verbal
1pm	**RISK AND RESILIENCE**		
7.	**Corporate Risk Register** Report by the Director of Security, Resilience and Estates	For Decision	Paper No. 23/41
8.	**Operational Response Plan** Report by the Director of Nursing and Operations	For Decision	Paper No. 23/42
9.	**Risk and Resilience: Annual Report 2022/23** Report by the Director of Security, Resilience and Estates	For Noting	Paper No. 23/43
10.	**Infection Prevention and Control Report** Report by the Director of Nursing and Operations	For Noting	Paper No. 23/44
11.	**Bed Capacity Report:** **The State Hospital and Forensic Network** Report by the Medical Director	For Noting	Paper No. 23/45
1.35pm	**CLINICAL GOVERNANCE**		
12.	**Clinical Model Implementation – Update**	For Decision	Paper No. 23/46

	Report by the Medical Director		
13.	**Clinical Governance Committee – Annual Report** Report led by the Committee Chair	For Decision	Paper No. 23/47
14.	**Quality Assurance and Quality Improvement** Report by the Head of Planning and Performance	For Noting	Paper No. 23/48
15.	**Clinical Governance Committee** - Approved minutes of meeting held 9 February 2023 - Update from meeting 11 May 2023	For Noting	CGC (M) 23/01
2.05pm	**** BREAK****		
2.20pm	**STAFF GOVERNANCE**		
16.	**Staff Governance Committee – Annual Report** Report led by the Committee Chair	For Decision	Paper No. 23/49
17.	**Remuneration Committee - Annual Report** Report led by the Committee Chair	For Decision	Paper No. 23/50
18.	**Staff Governance Report** Report by the Director of Workforce	For Noting	Paper No. 23/51
19.	**Annual Review of Workforce Plan – Update** Report by the Director of Workforce	For Noting	Paper No. 23/52
20.	**Staff Governance Committee** - Approved minutes of meeting held 16 February 2023 - Update from meeting 18 May 2023	For Noting	SGC (M) 23/01
2.50pm	**CORPORATE GOVERNANCE**		
21.	**Report on the Annual Accounts – 2022/23** Report by the Audit Committee Chair	For Decision	Paper No. 23/53
22.	**Audit and Risk Committee – Annual Report** Report led by the Committee Chair	For Decision	Paper No. 23/54
23.	**Patient Funds Accounts – 2022/23** Report by the Director of Finance & eHealth	For Decision	Paper No. 23/55
24.	**Finance Report to 31 May 2023 (Month 2)** Report by the Director of Finance & eHealth	For Noting	Paper No. 23/56
25.	**Performance: Annual Report 2022/23** Report by the Head of Planning and Performance	For Noting	Paper No. 23/57
26.	**Network Information Security – Update** Report by the Director of Finance & eHealth	For Noting	Paper No. 23/58
27.	**Property and Asset Management Strategy** Report by the Director of Security, Resilience and Estates	For Noting	Paper No. 23/59
28.	**Perimeter Security and Enhanced Internal Security**	For Noting	Paper No. 23/60

	Systems Project Report by the Director of Security, Resilience and Estates		
29.	**Communications – Update** Report by the Head of Communications	For Noting	Paper No. 23/61
30.	**Audit and Risk Committee:** - Approved minutes – meeting held 6 April 2023 - Chair's Update – meeting held 22 June	For Noting	 AC(M) 23/02 Verbal
31.	**Any Other Business**		Verbal
32.	**Date of next meeting:** 9.30am on 24 August 2023		Verbal
33.	**Proposal to move into Private Session, to be agreed in accordance with Standing Orders.** Chair	For Approval	Verbal
34.	**Close of Session and Reflection on Meeting**		Verbal

Estimated end at 4pm

THE STATE HOSPITALS BOARD FOR SCOTLAND
ROLLING ACTION LIST

ACTION NO	MEETING DATE	ITEM	ACTION POINT	LEAD	TIMESCALE	STATUS
1	April 2022	QA and QI	Update on Carer's clinic workstream	Monica Merson	To be Updated: August 23	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. **Update: February 2023:** Delayed update due to vacancy arising in project manager role, this is being reviewed by Head of Planning & Performance. **Update April 2023**: redeployed nursing resource temporarily in place to support Realistic Medicine, and update to next Board meeting. PCIT aware of this workstream, but no direct involvement. **Update June 2023:** update to Clinical Governance Committee provided in May 2023: further clinics paused until end of clinical model moves, and then reviewed.
2	October 2022	Operational Response Plan	Update on trigger points of escalation and link to the Board resilience of loss of staff plan,	K McCaffrey	To be Updated: June 23	**Update December 22:** Paper presented to Board advising of Task and Finish Group being set up to complete this work. **Update February 23:** Group is underway, and continuing to meet – agreement that full revision of papers to be progressed in short time scale – update to Board in June 23

						Update April 23: Workstream on track and update will come to next Board meeting. **June 2023: On agenda – Item 8**
3	Feb 23	QA and QI report	Review of report structure to give summary highlighting /key issues	M Merson	To be updated April 23 – reviewed and closed	**Update:** Report reviewed and format changed to take this into account and give highlight reporting for April meeting. Board noted refreshed reporting at the meeting as action completed. **CLOSE**
4	Feb 23	QA and QI	Review of assurance reporting thread through board versus committees	G Jenkins/ M Smith	To be updated May 23 – reviewed and closed	**Update April 2023:** Commenced with Review of April agenda with Board Chair, and agreed of remit of items to committees as initial approach and this will be ongoing. Committee chairs also reviewing routing of business and will update Board Sec. Board development session in May will review Corporate Governance approach as a whole. **Update:** Board development Session in May reviewed approach, and will be taken forward through Corporate Governance blueprint. **CLOSE**
5	Feb 23	Workforce Report	More detailed exploration of trends /patterns of sickness absence – add profile of length of service as well as service area. Add longitudinal data	L McGovern	To be updated June 23	**Update April 2023:** Reporting reviewed and presented under new format and including areas highlighted. Board reviewed changes in reporting and asked for further development of themes for sickness absence which would also be reviewed at Staff Governance Committee. **Update: On agenda**
6	April 23	Finance	Provision of detail on PAIAW	R McNaught	To be updated June 23	**Update:** as part of reporting Item 24 **CLOSE**
7	April 23	NIS	Addition to workplan so standing item each meeting	R McNaught /M Smith	Immediate	**Added to workplan as standing item** **CLOSED**

Last updated – 13.06.23 – M Smith

Author:
Margaret Smith
Head of Corporate Governance 01555 842012

Paper No. 23/41

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 June 2023
Agenda Reference:	Item No: 7
Sponsoring Director:	Director of Security, Estates and Resilience
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

All risks are in date

3.3 Update on Proposed Risks for inclusion on Corporate Risk Register

FD99 – Compliance with NIS Audit
CMT asked that the risk of non-compliance with the ongoing NIS audit was considered as an addition to Finance Directorate Corporate Risk Register. The risk was reviewed by the Director of Finance and risk assessment shared with CMT. This was approved and added to the CRR in June 2023 and details the current control measures in place as well as mitigations that are still in development. eHealth are continuing to liaise with staff to ensure they are aware of their expectations regarding their submission requirements and they are continuing to support and monitor the situation. Work is underway to update existing policies and finalise those still in development, departments are working to find the resources to assist with the audit and assistance is being given to ensure forms and templates are completed correctly. Based on the current situation, the risk is currently graded as Moderate x Possible giving a Medium rating. Full risk assessment is available in Appendix 2.

3.4 Corporate Risk Register Updates

FD96 – Cyber Security
CMT highlighted that our current risk register did fully reflect our current Cyber Security arrangements. FD96 was refreshed to include all active and planned cyber security programmes that contribute to a safe and secure digital infrastructure. Mitigations include: restrictions on user accounts, anti-virus and threat detection software, national support, firewalls and backups. The risk assessment is currently graded as Moderate x Unlikely giving a Medium rating. Update was approved at CMT in June 2023. Full risk assessment is available in Appendix 3.

3.5 High and Very High Risk – Monthly Update

The State Hospital currently has **4** 'High' graded risks:

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: Given to CMT. Risk assessment updated to include redesigned MSRs. Security Refresh Project still underway. Datix: violent incidents rose in Q4 but have since reduced to normal levels. Data continues to be monitored, figures will be categorised and compared with new ward types moving forward.

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

Monthly Update: 82% remain overweight and obese, 6.4% refusals.

- SHC project manager post was pulled due to financial reasons.
- Physical Health guidance info information included within clinical model guidance – ongoing work in progress – continues, to be taken up by hub clinical teams
- Slim and Trim ' – need support to action a general wt management group, to support our patients after the HLG –. – this has been discussed and an outcome awaited to progress this further.
- Use of GLP antagonist/Liraglutide –TSH adopting- outcome awaiting from MAG – likely adopt on an individual basis following pathway being agreed and support from NHS Lanarkshire

- SHC action plan review and update Spring 2023. –Action Plan will be updated now by dietetics and health psychology in the absence of SHC project lead for discussion in June with project oversight group.

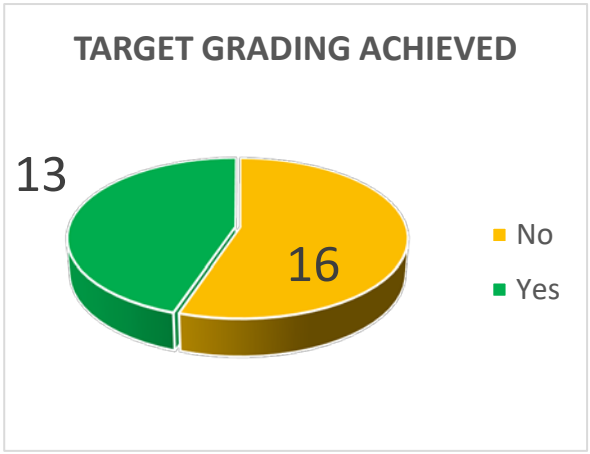
Nursing Director: ND70: Failure to utilise our resources to optimise excellent patient care and experience.

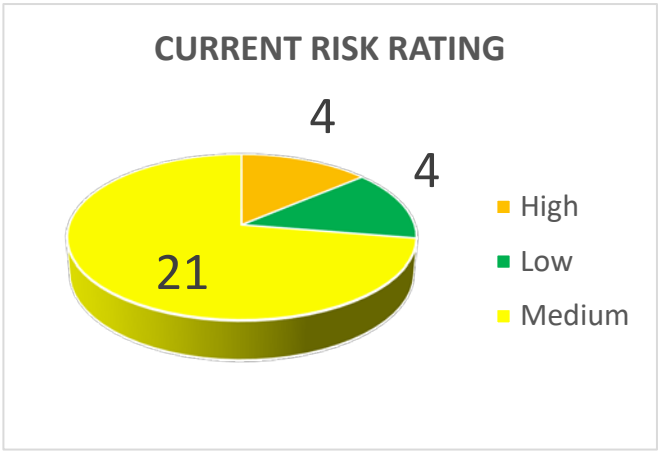
Monthly Update: Given to CMT. Risk assessment updated and in date. Datix: Staff resource continue to fluctuate, recent data shows increases in the number of Datix reports submitted. Continued effort to ensure impact on patient day is minimised.

Director of HR and Wellbeing: HRD111 – Deliberation Leaks of Information

Monthly Update: Updated Risk Assessment has been agreed. Meeting arrange to discuss the current grading with a view to reduce the risk grading. 2 Datix were submitted last week suggesting potential leaks from staff members, one article has been published with another still awaiting publication.

3.6 Risk Distribution





Currently 13 Corporate Risks have achieved their target grading, with 16 currently not at target level. 2 risks have been reduced since the last report, 2 from High to Medium, 1 of which is now at target level.

As per the TSH Risk Management Strategy, Low and Medium risks are tolerated within the organisation's 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 by the Risk Management Facilitator, risks are reviewed continuously and updated where required.

	Negligible	Minor	Moderate	Major	Extreme
Almost Certain					
Likely			ND70,	MD30,	
Possible			CE12, SD57, FD91, ND73, CE14, FD99	ND71, HRD111	
Unlikely			MD33, FD90, HRD110, FD96, FD98	MD34, SD51, SD50, SD54	
Rare			FD97, CE13, SD52, HRD112	MD32, SD56,	CE10, CE11, SD53, CE15

Review Periods:

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

3.8 Development of CRR

The Board undertook a self-assessment of its risk appetite, and how this impacts management of risk with support from RSM. As a result of this the Risk and Resilience Team are reviewing the current Corporate Risk Register arrangements. The aim of this review is to align the corporate risks with the strategic objectives and ensure that the risks contribute to TSH achieving its goals as a High Secure Hospital. As of June 2023 the team are currently reviewing all areas of high level monitoring and compliance including Corporate Objectives, Critical Success Factors and KPIs. This information will be collated and used to inform potential strategic risks that will be aligned to the four pillars of Better Care, Value, Health and Workforce. Regular updates will be provided to the board and development sessions will be planned with board members and directors.

4 RECOMMENDATION

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

Paper No. 23/41
MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	The report provides 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 Audit Committee Which groups were involved in contributing to the paper and recommendations	Board, 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. 23/41

High 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 MD 30	Medical	Failure to prevent/mitigate obesity	Major x Likely	Major x Likely	Moderate x Unlikely	Medical Director	Lead Dietitian	01/07/23	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 & AHP	Director of Nursing & AHP	01/07/23	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 & AHP	Director of Nursing & AHP	01/07/23	Clinical Governance Committee	Monthly	-
Corporate HRD 111	Reputation	Deliberate leaks of information	Major x Possible	Major x Possible	Moderate x Unlikely	HR Director	HR Director	16/06/23	HR and Wellbeing Group	Monthly	-

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	18/07/23	Corporate Governance Group	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	18/07/23	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	18/07/23	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	Major x Almost Certain	Moderate x Possible	Minor x Possible	Chief Executive	Chief Executive	18/07/23	Corporate Governance Group	Quarterly	-

		a safe and secure environment for patients and staff.									
Corporate CE15	Reputation	Impact of Covid-19 Inquiry	Extreme x Likely	Extreme x Rare	Extreme x Rare	Chief Executive	Board Secretary	01/07/23	Covid Inquiry SLWG	Monthly	↓
Corporate MD 32	Medical	Absconsion of Patients	Major x Unlikely	Major x Rare	Moderate x Rare	Medical Director	Associate Medical Director	09/09/23	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	09/09/23	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	09/09/23	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	18/07/23	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	18/07/23	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	18/07/23	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	18/07/23	Security, Risk and Resilience Oversight Group	Quarterly	-
Corporate SD 54	Service/Business Disruption	Implementing Sustainable Development in Response to the Global Climate Emergency	Major x Likely	Major x Unlikely	Moderate x Rare	Security Director	Head of Estates and Facilities	09/09/23	Security, Risk and Resilience Oversight Group	Monthly	↓
Corporate SD57	Health & Safety	Failure to complete actions from Cat 1/2 reviews within appropriate timescale	Moderate x Possible	Moderate x Possible	Moderate x Unlikely	Finance & Performance Director	Head of Corporate Planning and Business Support	18/07/23	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 & AHP	Director of Nursing & AHP	09/09/23	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 & Performance Director	Finance & Performance Director	06/07/23	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 & Performance Director	Head of eHealth	06/07/23	Finance, eHealth and Performance Group	Quarterly	-
Corporate FD 96	Service/Business Disruption	Cyber Security	Moderate x Unlikely	Moderate x Unlikely	Moderate x Rare	Finance and Performance Director	Head of eHealth	06/07/23	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 Performance Director	Head of eHealth/ Info Gov Officer	06/07/23	Finance, eHealth and Performance Group	Quarterly	-
Corporate FD 99	Reputation	Compliance with NIS Audit	Major x Likely	Moderate x Possible	Moderate x Rare	Finance and Performance Director	Head of eHealth	06/09/23	Finance, eHealth and Performance Group	Quarterly	NEW
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	HR Director	12/09/23	HR and Wellbeing Group	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	01/06/23	Corporate Governance Group	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	01/011/23	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 Performance Director	Head of eHealth	06/10/23	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	HR Director	Training & Professional Development Manager	12/12/23	Clinical Governance Group	6 Monthly	-

Appendix 2

Compliance with NIS Audit Ref: FD99

Corporate Objective	**Better Value**	**Risk Owner**	**Robin McNaught**	**Action Officer**	Thomas Best/Heads of Service

Risk	Complete the relevant details of the operation/ activity giving risk to the risk
Network and Information Systems Compliance	

Category		Tick the box to indicate the type of risk Descriptions of categories and level of impact are available in TSH Risk Matrix
Patient Experience	☐	
Objectives/ Project	☒	
Injury (physical or psychological)	☐	
Complaints/ Claims	☐	
Service/ Business Interruption	☐	
Staffing and Competence	☐	
Financial (inc damage, loss or fraud)	☒	
Inspection/ Audit	☒	
Adverse Publicity/ Reputation	☐	
Physical Security	☐	
Other (Specify)		

Hazards		Details the hazards associated with this risk, i.e. the effect. Impact of this risk if realised
Lack of evidence to show compliance with Public Sector Cyber Resilience Framework (PSCRF). Lack of time to obtain required evidence of compliance with PSCRF.		
Individuals or group exposed	Board/Hospital	Highlight those who would be affected by risk

Benefits	Detail any benefits associated with this risk being mitigated. (e.g. cost savings)
Compliance with Legislation, Secure Networks, and Information systems.	

Existing Control Measures	List any existing measures in place to mitigate this risk.
Deadline for evidence submission is 16th October 2023 but work is starting now to gather evidence. Assessing evidence submitted during the previous cycle and concentrating on areas where there was lack of evidence. Communication with key stakeholders has already started.	

Central location for evidence submission and monitoring now in place.	

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	Major	Likely	High
Target Movement Movement since last review	-	-	-
Target Risk Rating	Moderate	Rare	Low
Current Risk Rating	Moderate	Possible	Medium

Further Control Measures Required	Include any additional controls identified to eliminate or reduce the risk further.
Additional resources to assist with collection of evidence. Other departments to correctly complete the evidence templates provided. New policies to be developed or updated. New documentation to be developed. All directorates/departments that need to submit evidence should have it listed as a high priority. Lack of evidence needs to be addressed sooner rather than later, even if there is a draft version of a policy/procedure/process that can be submitted.	

Assurances and KPIs	What assurances are there that current controls are effective? (Internal and external) Detail any existing KPIs that would link to risk and show performance against risk
More time is being dedicated to the planning and organising of the evidence being collected. Regular meetings are being setup to ensure all key stakeholders understand the importance of evidence submission, this will also give a platform to highlight issues or challenges to adoption.	

Date Added	June 2023
Completed by	Robin McNaught
Date Reviewed	05/06/2023
Next Review	05/09/2023

Risk Register	Corporate Risk Register
Directorate	Finance and eHealth
Group/Committee Monitoring Risk	Finance and Performance Group/CMT

Appendix 3

Cyber Security Ref: FD96

Corporate Objective	Better Workforce	Risk Owner	Director of Finance & eHealth	Action Officer	Head of eHealth

Risk	Complete the relevant details of the operation/ activity giving risk to the risk
Cyber attack on TSH digital infrastructure	

Category		Tick the box to indicate the type of risk Descriptions of categories and level of impact are available in TSH Risk Matrix
Patient Experience	☐	
Objectives/ Project	☐	
Injury (physical or psychological)	☐	
Complaints/ Claims	☐	
Service/ Business Interruption	☒	
Staffing and Competence	☐	
Financial (inc damage, loss or fraud)	☒	
Inspection/ Audit	☐	
Adverse Publicity/ Reputation	☒	
Physical Security	☐	
Other (Specify)		

Hazards		Details the hazards associated with this risk, i.e. the effect. Impact of this risk if realised
• Cyber attack on TSH digital infrastructure ie. ransomware or wiper attack that prevents access to systems, compromises data or prevents access to systems. • Financial implications to resolve issue with potential to pay fines. • Reputational damage		
Individuals or group exposed	Staff, Patients, Carers and Volunteers	Highlight those who would be affected by risk

Benefits	Detail any benefits associated with this risk being mitigated. (e.g. cost savings)
Managing this risk ensures TSH has a safe and secure digital infrastructure and provides assurance to stakeholders that any potential threats can be managed.	

Existing Control Measures	List any existing measures in place to mitigate this risk.
• Maintain computer patching	

• Reduced end user rights and restrictions on staff/patient user accounts • Sophos Anti-Virus with Intercept X (that detects multiple encryption attempts), anti malware and ransomware protection. • Windows 10 devices Advanced Threat Protection (ATP) which is monitored nationally. • End user awareness of malicious emails, regular communications and Data Protection training given to all staff. • Any documentation meets standard of ISO27001:2013 • All desktop and laptop computers support Windows 10 and all corporate systems are updated to the latest patch level available. • Support from the National CSOC (email scanning and detection, SWAN monitoring and updating). • Solutions are in place to segregate our storage and backup solutions ensuring any malicious actors would be unable to compromise them easily. • We run regular backups of all our systems with data backups on physical storage (live and immutable) which are also copied to tapes and located in a fireproof safe in a different building. • Our Internet access is restricted to the Scottish Wide Area Network (SWAN). This is monitored 24/7 and is protected by two firewalls. SWAN also has protected DNS capability to protect against a denial of service. We also have two additional firewalls on site. The multiple networks within the hospital are segregated with encryption in places to reduce the vectors malicious actors could utilise. • We also have 802.1X authentication network access control system in place to prevent the connection of non-approved devices connecting to our network. • User accounts are disabled on notification from HR and Security reception when users leave. • External access is limited to the least number of connections possible with time restrictions and segregated machines for support contractors.	

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	Major	Likely	High
Target Movement Movement since last review	-	-	-
Target Risk Rating	Moderate	Rare	Low
Current Risk Rating	Moderate	Unlikely	Medium

Further Control Measures Required	Include any additional controls identified to eliminate or reduce the risk further.
• Initiate regular backup testing. • Cyber desktop response exercises (exercise in a box). • Staff training modules to be updated. • Cyber security training (Executive level). • Cyber security training (eHealth IT Infrastructure staff). • Finalise Level 1 plan and begin regular business continuity plan testing. • Increased monitoring of cyber security threats. • Regular penetration testing (Digital and physical) • Improved incident response awareness and monitoring. • Improved project management to include information security.	

Assurances and KPIs	What assurances are there that current controls are effective? (Internal and external)
• Datix used to monitor incidents, staff encouraged to report any attempts and phishing, malicious emails etc • Regular scans and updates of digital infrastructure	

• Support from nationally supported system (SWAN) •	Detail any existing KPIs that would link to risk and show performance against risk

Date Added	January 2019
Completed by	Robin McNaught/Thomas Best/Stewart Dick
Date Reviewed	27/04/2023
Next Review	27/07/2023

Risk Register	Corporate Risk Register
Directorate	Finance and eHealth
Group/Committee Monitoring Risk	Finance and Performance Group

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 June 2023
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/ Head of Risk and Resilience
Title of Report:	Operational Support Plan - Update
Purpose of Report:	Noting

1 SITUATION

There was agreement to review the loss of staff plan at the October 2022 Board meeting.
The Patient Safety Group then commissioned a short life working group to undertake this work, reviewing the following:

-The Loss of Staff plan.

-The use of available data, including DATIX reporting.

-Reduce use of modified working and ward closures.

The SLWG reports into the Patient Safety group, the Director of Nursing chairs this group and will also report back to CMT, who provides an update for the Board.

The purpose of today's report is note the revision of Loss of Staff plan, which has been renamed the **Operational Support Plan**. As well as provide a brief update regarding the other two elements covered by the SLWG.

2 BACKGROUND

As previously advised, the introduction of Safe to Start has provided 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 measures was put in place, which ensured the delivery of safe care. Therefore, the trigger for the loss of staff plan, including percentage of staff lost, required review and revision.

3 ASSESSMENT

Operational Support Plan - When revising the current Loss of staff plan & Extreme loss of staff plan, with the benefit of the learning gained throughout the pandemic, the SLWG agreed that staffing resourcing issues alone, were unlikely to require an incident command response. Incident command would more likely be required when there were a combination of other issues identified or the minimum staffing (night shift) model could not be achieved.
The revised plan reflects this and outlines the robust oversight of staffing resource within the State hospital. Also, provides an over view of the levels of escalation in place and the factors which would be considered as a trigger to move to an incident command position. There is then clear direction regarding the step down process to Business as usual.

Ward closure / Modified working – Here the focus is to understand the factors contributing to the use of modified working and closing wards and move these back to being “never events” thereby reducing the unnecessary time patients spend in their rooms.

There were clear definitions of modified working practices provided to staff. However, the available data including feedback from patients, indicates variation in the application of these.

There has now been a clear instruction given to all staff that there should be no modified working when we are assessed as RAG status Green. The current RAG status is currently being revised as part of the early implementation of the safe staffing legislation. There is also work to reduce the circumstances where wards would be closed. Partial closure will be removed from the list of definitions, as there is little difference from a patient experience perspective between this and modified working.

There, is ongoing work to improve the consistent application and practices which maximise activity during periods of modified working. Whilst a process mapping exercise has been undertaken, to fully understand all that contributes to this current practice. Following which a SLWG will oversee the progression identified pieces of work.

This multi-pronged approach will not only enable the reduction of modified working but also ensure the improvements are sustainable. The progress of which will be overseen by the Chief Exec, Director of Nursing & Operations & Medical Director and regular updates provided to CMT.

Use of available data - The Patient Safety group received a report from the Head of Risk management, 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.

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 have been changes made to the DATIX reporting including follow-up questions to enable us to understand more fully the impact on service delivery and patient experience. This information can then be pulled into a tableau dashboard. This provides the opportunity to not only see the site wide picture and identify any outlying areas but can also look at individual wards and understand the impact of the measures in place.

The dashboard once finalised will give timely and accurate information which can then be used to report the level and impact of modified working, and ward closures. This data will also indicate if the other strands of improvement work identified through the process mapping process is enabling us to achieving our stated aim.

Next steps

- Process mapping to be completed and findings pulled together in a report
- Further focus on Modified working and reducing it's application
- Review data from drop down questions on DATIX to see if cover all aspects required.

4 RECOMMENDATION

Note the content of the paper and the completed revision of the Operational Support Plan.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives?	Aims to reduce modified working practices
Workforce Implications	Staff time required for improvement work
Financial Implications	None identified at present
Route to the Board (Committee) Which groups were involved in contributing to the paper and recommendations?	Updates through Clinical Governance
Risk Assessment (Outline any significant risks and associated mitigation)	
Assessment of Impact on Stakeholder Experience	Impact on patients reported through PPG and through complaints and feedback processes.
Equality Impact Assessment	

Paper No. 23/43

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 June 2023
Agenda Reference:	Item No: 9
Sponsoring Director:	Director of Security, Estates and Resilience
Author(s):	Risk Management Facilitator / Head of Risk and Resilience
Title of Report:	Risk & Resilience Annual Report 2022/23
Purpose of Report:	For Noting

1 SITUATION

The Risk and Resilience Annual Report report provides The Board with details of the activity undertaken within the Risk and Resilience department over period 1 April 2022 until 31 March 2023.

2 BACKGROUND.

The Risk and Resilience Department is involved in a range of functions from the maintenance of risk registers, development and review of Resilience Plans, Incident Reporting and Enhanced Reviews, Health & Safety, Duty of Candour to the administration

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

Report is provided to The Board each year prior to publication.

3 ASSESSMENT

Areas of Good Practice

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

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

Areas of good practice within the risk management department include:

- Development of the Corporate Risk Register with risk owners, the risk register continues to see positive movement over the last year as a result of further control measures being

implemented. High risks are now monitored monthly with a focus on reducing risks. Further development is continuing into 2023/24.

- Updated Local Risk Register work completed and now fully in use across TSH.
- Department delivered an array of training programmes across the hospital including Incident Command, Datix Training, Control Book Training and supported the negotiator training programme – all of which upskilled staff and increased our level of resilience.
- Audit from RSM completed in March 23 which focused on our incident management processes. We received positive comments from the auditors and received a 'reasonable' recommendation score which was the second highest score available. Work is underway to close the few actions recommended from the audit.
- Datix Incident Reporting System received many updates throughout 2022/23 including updated categories to capture better data, introduction of the staff hot and cold debrief process to Datix and updating the way staffing resource incidents are coded. Work will continue on the system throughout 2023/24 to ensure we are capturing high quality data that is useful in the management of incidents.
- Continued development within the Risk and Resilience Team including the Risk Management Facilitator achieving their NEBOSH Health and Safety qualification. They also completed other training programmes including Managing difficult conversations with HIS and NEBOSH Wellbeing in the Workplace. They continue to work closely with departments within the hospital and work with all disciplines to ensure that they have a strong relationship with risk management and learning from incidents. The role of Risk Management Facilitator has also changed over the last couple of years and is going through the Agenda for Change process. This will provide extra resilience for the department and open new avenues of work streams.
- Head of Risk and Resilience was able to build strong relationships with many external partners, embed themselves in the organisation, organisation and provide training courses covering different aspects of resilience as well as build on their skills through various courses and training programmes.
- Control Books were identified as an issue in the previous annual report. In 2022/23 over 20 staff were trained and 4 control books audited. This will make a positive impact on the future of the control book programme as audits continue into 2023/24.

Identified issues and potential solutions

The main focus for the Risk and Resilience Team in 2022/23 will be to review our Health and Safety Management System. The first step will be to recruit a permanent part-time Health and Safety Advisor with a focus on reviewing our current arrangements and how to move them forward.

There is also a vacancies within the department for the Risk Support Officer Role and Security and Resilience Trainer. Once in post this will free up time for the Risk Management Facilitator to focus on areas that require further development.

Future areas of work and potential service developments

RSM have worked with Directors and Board Members to help deliver an updated risk appetite document. Work will continue with this in 2023/24 as the Risk and Resilience Team reviews our Corporate Risk arrangements. The aim for this year is to produce a Corporate Risk Register that aligns with the strategic aims of the hospital.

A lot of progress was made on the Datix system in 2022/23 however this will continue in 2023/24 as the teams looks to optimise the Datix system and the way information is recorded, produced and analysed.

Risk and Resilience Team will continue to raise profile across hospital and continue to help the organise mitigate risk, increase resilience and learn from incidents.

4 RECOMMENDATION

The Board is invited to note the Risk and Resilience Annual Report for the period 2022/23.

MONITORING FORM

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

THE STATE HOSPITALS BOARD FOR SCOTLAND

Risk and Resilience Annual Report

2022-23

Prepared by: Risk Management Facilitator & Head of Risk and Resilience

Approved by: Director of Security, Estates and Resilience

Contents

1. Risk Management Department

1.1 Introduction

The Risk and Resilience Department, part of the Security Directorate, is involved in a range of functions from the maintenance of risk registers, development and review of Resilience Plans, Incident Reporting and Enhanced Reviews, Health & Safety, Duty of Candour to the administration of Datix.

1.2 Aims and Objectives

- Development, implementation and review of Risk and Resilience policies and procedures;
- Proactive identification of risks potentially impacting on The State Hospital (TSH), with the subsequent management of these risks through recognised risk management tools and techniques;
- Implementation of Incident Review processes to ensure significant adverse events are adequately investigated with the development of Action Plans to enhance organisational learning; and
- Supporting a "Quality" culture by developing staff competencies and improving risk management practices within TSH.
- Develop and maintain how we respond in times of crisis by maintaining a resilient hospital,that can adapt and operate outwith normal parameters.
- Develop and maintain relationships with our partner agencies, having a shared understanding and opportunity to learn.

2. Governance

2.1 Committees/Groups

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

The Risk Management process has been embedded within all the TSH committees and groups, with members of the team present at the majority of the groups. Regular reports on risk activity are presented to the Security and Resilience Group, Climate Change and Sustainability Group and Health, Safety and Welfare Committee with oversight from the Security, Risk, Resilience, Health and Safety Oversight Group. Relevant incidents, the corporate risk register and policy management are also reported to the Audit, Clinical Governance and Staff Governance Committees on a quarterly basis.

An example of some of the main groups Risk and Resilience report to are below:

- **Health, Safety and Welfare Committee (HSW)** operates in partnership with staff, and plays a key role in monitoring and reviewing Health and Safety incidents and policy implementation.
- **Security and Resilience Group (SRG)** monitors and reviews progress on emergency and resilience plans, ensuring that core plans are in place, tested and reviewed, with the minutes being reported to the CMT.
- **Climate Change and Sustainability Group (CCSG)** aims to ensure that the principles of sustainability are embedded in NHS The State Hospital Board for Scotland's strategic programme. The Group will ensure an integrated approach to sustainable development, harmonising environmental, social and economic issues.
- **Security, Risk & Resilience, Health & Safety Oversight Group** oversees the progress of HSW Committee, SRG and CCSG. The purpose is to govern and direct work across all three sub-groups to align to the overall strategy for the hospital.
- The committee and groups report issues to the **Audit Committee** after each meeting and the minutes are circulated at that committee.
- **Organisational Management Team** is the main operation group within the hospital. Risk and Resilience have a presence at both these meetings to provide updates on current risk

and resilience work as well as receive and monitor actions. This group feeds into the **Corporate Management Team.**

- **Patient Safety Group** for which a report is prepared separately on an annual basis for Clinical Governance Committee.

In addition to the above Groups and Committees. Risk and Resilience also have a presence at other Hospital Groups including Infection Control, Information Governance, Corporate Governance and Clinical Governance.

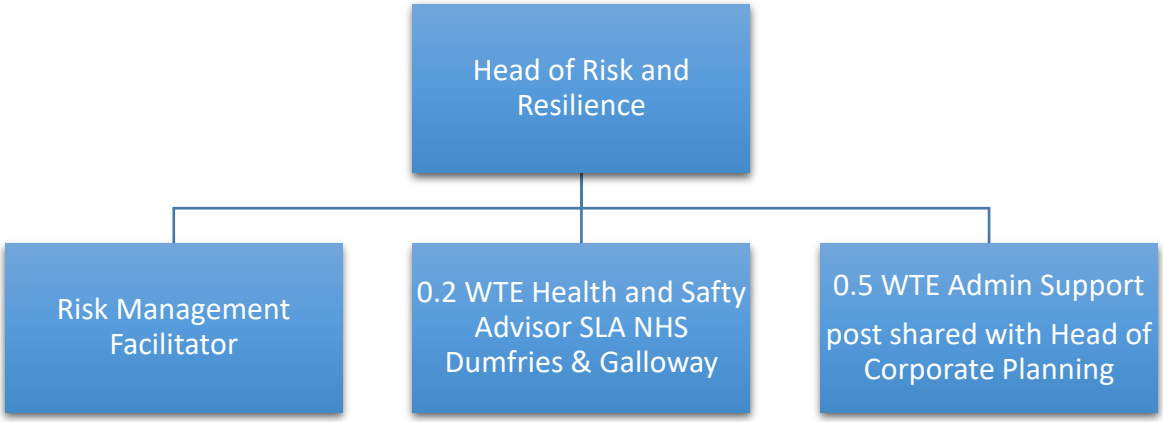
3. Key Work Activities (2022-2023)

3.1 Risk and Resilience

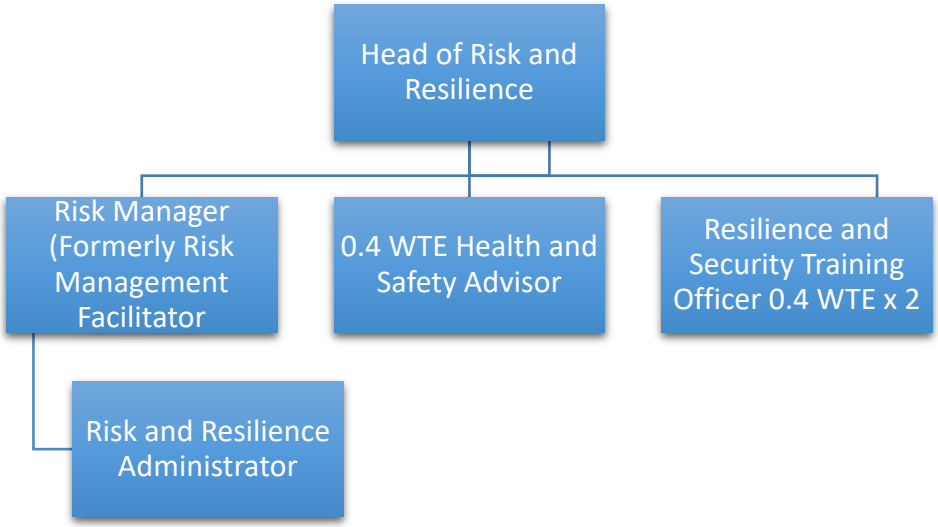
3.1.1 Changes within Department

In order to focus and develop the department it has been agreed to expand and review roles within the team to reflect the needs of the hospital.

Current Model as of 2022/23



Planned Model for 2023/24



This model was developed to better incorporate the need for resilience support, security training, Health and Safety and a focused approach to analysis of Risk with development of the Risk and Resilience portfolio.

3.1.2 Corporate Risk Register (Appendix A)

A corporate risk is a potential or actual event that:

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

Appendix A contains the current Corporate Risk Register containing 28 risks spread across the 6 Directorates. Risks are reviewed regularly throughout the year with updates shared with CMT and The Board. 4 of the risks were graded High with the rest following in the Medium and Low gradings.

A project is underway to update the Corporate Risk Register and ensure it aligns with the strategic aims of the hospital. This will be presented to the Board in 2023/24.

3.1.3 Department/Local Risk Registers

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

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

The process for the Local Risk Register continued to be managed by the Risk Management Facilitator with each department within the hospital having an active register which is reviewed frequently. The register continues to develop in response to changes within the hospital environment. This is managed by members of the Organisational Management Team.

CMT are updated on progress by the Director of Security, Estates and Resilience.

3.2 Resilience

The Head of Risk and Resilience has overall responsibility for the management of Resilience within TSH on behalf of the Director of Security, Estates and Resilience. The Director also chairs the Security, Risk and Resilience, Health and Safety oversight group and Security and Resilience Group. The Risk and Resilience Department also produces an annual report for the Boards' Audit Committee and regular Resilience Reports to the relevant groups.

3.2.1 Resilience Plans

Level 2 Plans are primarily Loss of Service Plans and are handled by our internal operations. No external assistance from partner agencies are required therefore, command structure is minimal for control and return of operations. Normally return to normal operations is swift and is controlled within normal service functions and operations.

Currently, all level 2 plans are in date with the exception of eHealth. These plans are in active development and will be finalised shortly.

Level 3 Plans

Our current level 3 plans remain fit for purpose and all agencies are content with current arrangements. Our level 3 plans are those of a multiagency joint working model. These plans involve input from our partner agencies, Police Scotland, Scottish Fire and Rescue, Scottish Ambulance Service, South Lanarkshire Council and the West of Scotland Regional Resilience Partnership. Work continues to develop and refresh Level 3 plans in a the format that are easily understood.

3.2.2 Resilience Related Incidents

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

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

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

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

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

Over the year April 22 – March 23, there have been 0 level 3 and 8 level 2 incidents plus 3106 relating to staffing.

	2018/19	2019/20	2020/21	2021/22	2022/23
Level 2	4	2	0	19	8 (+ 3106 staffing resource)
Level 3	0	0	4	0	0

Level 2 incidents covered a rage of areas from Security Systems to eHealth and Heating Systems. All incidents were resolved internally with only minimal disruption, no incidents required escalation to Level 3.

No Level 3 incidents were reported in 2022/23, the hospital will continue to monitor and report all disruptions to day to day operations.

3.2.3 Training and Exercising

Risk Management Training

A review of the current Control Book arrangements has taken place due to changes in departmental management structures, locations and roles. 29 staff were identified as a Control Book or Deputy Control Book requiring initial training. 4 training sessions were scheduled and 23 of the identified staff attended.

Datix Training was provided to 21 staff in management roles. The training aims to teach staff how to use the Datix system, quality check all Datix entries, investigate Datix entries thoroughly and how to interrogate the system for data. Training for Datix runs continuously and is provided by the Risk Management Facilitator.

Resilience Training

In July 2022 a total of 28 staff were trained in Level 3 PPE. This has been tested and the policy was approved for use in Feb 2023. To date it has not been deployed.

In partnership with Police Scotland a bespoke Critical Incident Communicator (previously known as Negotiators) course was developed based on the full training that Police Scotland deliver to operational officers, while also incorporating the needs of the hospital. This training opportunity was offered to staff to across the site who were invited to apply. At total of 14 staff were successful in passing the course are now fully trained in this new role.

Silver Command Training was delivered training to three new senior leaders to ensure they are capable and comfortable managing events of an operational nature. This consisted of two days training for each senior leader to develop knowledge then finally and a mock exercise to consolidate the learning.

Gold Command Training was also provided in 2022/23. We introduced our staff to decision making models, incident command structure, resilience plans and escalation process to enable them to deal with a developing incident on-site. This is a one day course that develops knowledge and then culminates in a mock exercise to consolidate learning. In the last twelve months a total of 10 staff were trained in this role. 8 new and 2 refresher.

3.2.4 Partner Agency Working

It is important to maintain and develop our relationships with our partner agencies, who at times we may rely upon to assist us during times of crisis. Our partner agencies include the following:

- Police Scotland
- Scottish Fire and Rescue
- Scottish Ambulance Service
- South Lanarkshire Council
- West of Scotland Resilience Partnership

Below highlights the work that has been undertaken in the last 12 months to develop relationships with TSH partner agencies:

Police Scotland

Over the past twelve months relationships have strengthened with Police Scotland with the following milestones achieved:

- Police Scotland has created a dedicated response team for the hospital. Since introduction this has borught forward a consistent approach in all policing matters. This is led by the local community Sergeant and a team of 3 community officers, who now have an active relationship with the hospital and work closely with the Security Team. Security staff are already seeing benefits from this relationship.
- An overview presentation of the State Hospital was provided to all response policing teams covering this area. The response teams are the first on scene for any incidents and the presentation provided details of how the hospital operates and has received positive feedback.
- Developed an updated "*memorandum of understanding"* with Police Scotland. This provides details to reach agreement on primacy and levels of autonomy during incidents. This is awaiting legal sign off.
- STORM plan. Following a recent incident where firearms were deployed TSH have engaged with Police Scotland Tactical Firearms Unit to help them gain a better understanding for their Incident Commanders and decision makers. The firearms unit has developed a full intelligence

plan. This will allow Force Overview Inspectors make an informed decision before taking a decision to deploy firearms is reached. This is critical in regards to response and expectations.

- 3D modelling options are being explored with a view to creating a virtual hospital environment for incident purposes. This allows an operation overview in real time for anyone faced with an incident in the hospital. This type of work also is of great benefit to the hospital, as it would also allow us to create a virtual tour of the premises for talks, presentation and visitors. This is still in development.
- Continued work with Police Scotland negotiation team
- Operational familiarisation visits to the hospital with key departments.

Scottish Fire and Rescue

Over the last twelve months the following milestones were achieved:

- Restarted operational familiarisation visits to the hospital with key departments. This is an important aspect for the fire service to understand the risks on site
- Development of Operational Intelligence to allow incident commanders to understand and plan tactical interventions for an incident within the hospital
- Development of exercises, utilising the SFRS training and development team to engage and develop training scenarios that will test both our operational plans but also test the response of the fire service, with a hope to deliver a full exercise in the 1st quarter of next year.
- Maintain and develop relationships and shared opportunities

Scottish Ambulance Service

Re-engaging with the Scottish Ambulance Service is the next stage in our resilience development for the department. This process has already started with intial meetings taking place but needs more development. The development will be similar to that of the other partner agencies, whereby we will learn from each other and develop a shared understanding of expectations.

South Lanarkshire Council

As part of the local LRP we work closely with South Lanarkshire Council. We have facilitated familiarisation visits for new to role staff to help them understand hospital activity and allow opportunity to develop shared learning of what we can both offer if required. This work will continue.

3.2.5 NHS Standards for Organisational Resilience

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

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

Scottish Government(SG) are currently reviewing the resilience standards looking to develop and adapt new ones to work too. This remains an ongoing objective for SG. Risk and Resilience are working in line with these current standards where applicable.

3.3 Health & Safety

3.3.1 Control Book Audits

Currently, Health & Safety electronic Control Books (eCB's) provide the infrastructure to manage Health & Safety arrangements across TSH. This was a service provided by NHS Lanarkshire for which the service level agreement has now ended. The State Hospital will remain using Control Books until a new H&S Advisor is appointed and the arrangements will be reviewed.

TSH currently operate around 30 eCB's hosted on TSH's intranet which are audited within a 2-year cycle to ensure compliance with organisational and local policies/procedures.

Control Book Audits restarted in 2022/23 focusing on the areas with the lowest scores. The control books identified as priority were successfully audited with all 'Green' scores with the exception of one which was given an amber score, a work plan was developed to improve the score at the next audit.

The remaining Control Books will be audited in 2023/24 and continue to be reported and monitored by the Health and Safety Committee.

3.3.2 2022/23 Training Plan

A training plan was created for 2022/23 to target new and deferred control books as well as any staff who require further training to improve audit score. Staff in new posts who have been allocated as Control Book Holder have also been targeted for training.

29 staff were identified as a Control Book or Deputy Control Book Holder who required to attend their initial training. 4 training sessions were scheduled which 23 of the identified staff attended.

Future training will be provided on a 1-1 basis and delivered by Risk Management Facilitator and the Health and Safety Advisor. This session will include detailing the requirements for the control book, how to complete risk and assessments and how to manage the control book in general.

Training service will be updated in 2023/24 with the appointment of permanent Health and Safety Advisor.

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

RIDDOR requires employers to report incidents that 'arise out of or in connection with work resulting in: the death of any person; specified injury to any person or hospital treatment to non-employees; employee injuries resulting in over 7-day absence from work; dangerous occurrences and specified occupational diseases'. There has been an increase of 3 in reported RIDDOR incidents in comparison to 2021/22.

	Q1	Q2	Q3	Q4	2020/21	2021/22	2022/23
'Specified' Injuries*	1	0	0	0	**2**	**1**	**1**
Over 7 day lost time Injury	0	1	2	4	**2**	**4**	**7**
Total	1	1	2	4	**4**	**5**	**8**

RIDDORs reported came from a variety of incidents including Slips, Trips and Falls, Moving and Handling and PMVA. All reported incidents were investigated by the relevant manager or person responsible. Relevant action was taken if required and staff supported by their managers and Occupational Health. All RIDDORs were reported to the Health and Safety Executive timeously in line with legislative requirements, TSH has not been notified of any further action to be taken as a result of our reported incidents.

Incidents will continue to be monitored through Datix and the Risk and Resilience Team will support the RIDDOR notification process where required.

3.4 Fire

Four fire alarms occurred during the year to which all received a response from Scottish Fire & Rescue Service. No actual fires were present in TSH.

3.5 Incident Reporting

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

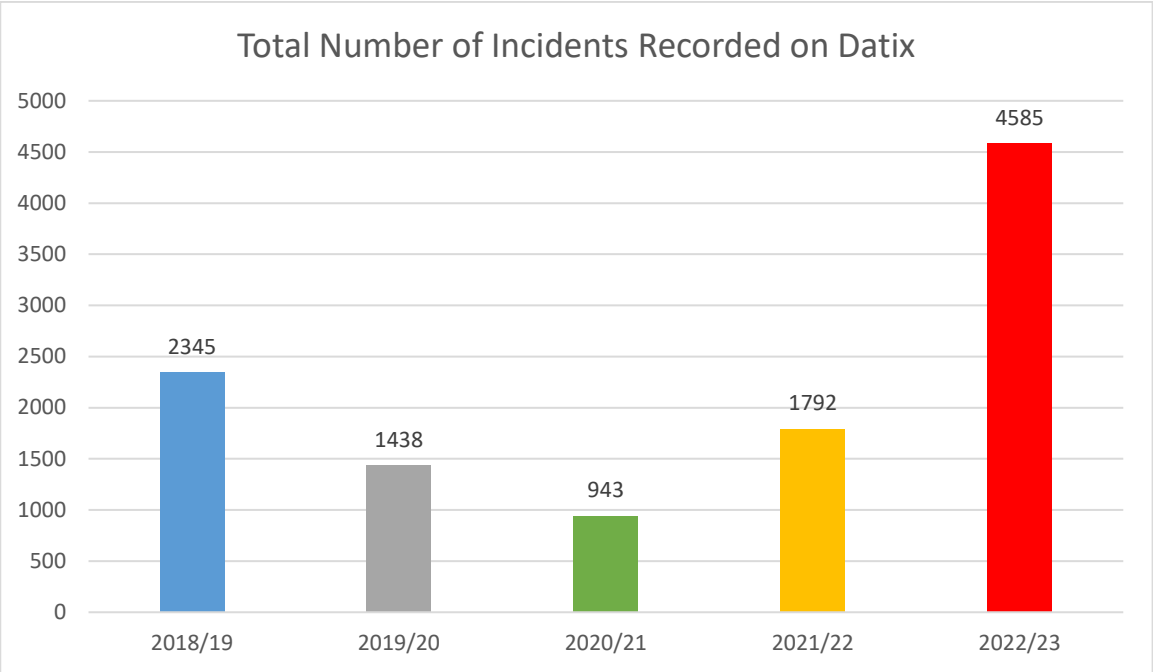
Each reported incident is investigated locally to ensure appropriate remedial and preventative steps have been taken. There are clear processes in place to identify incident trends or significant single incidents.

Datix classifies 7 overarching 'Type' of incident:

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

3.5.1 Datix Incidents

4585 incident reports were finally approved during 2022/23; a significant increase in the number of incidents finally approved in 2021/22 (1792). The chart below shows the changes in the number of incidents reported within Datix over the last 5 years. The significant increase is due to the improved compliance reporting of Staff Resource Incidents on the Datix System, although many other categories did also show an increase. (See below)



3.5.2 Incident 'Type' Trends over last 5 years

Incident Type	2018/19	2019/20	2020/21	2021/22	2022/23
Staffing Resource	X**	X**	X**	X**	**3192**
Health & Safety	1095	712	413	461	**660**
Security	396	138	93	139	**277**
Direct Patient Care	214	146	142	146	**206**
Equipment/Facilities/Property	117	106	78	75	**105**
Infection Control	46	82	55	60	**77**
Communication/Information Governance	51	32	48	65	**51**
Other	426	219	115	846	**11**
Totals	2345	1435	943	1792	**4585**
*Average Patient Population	107	106	114	115	110

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

** Staffing resource is recorded separately as of 2022/23, previously it was recorded under 'Other'.

In comparison with the figures for 2021/22, there has been an increase in the number of incidents reported in all categories with the exception of Communication Governance. 'Other' Category no longer reflects staffing resource incidents as they are reflected separately.

The number of incidents recorded in 2022/23 has more than doubled on the previous year going from 1792 to 4585. This has been fuelled by the rise in incidents under 'Staffing Resource'. Reporting in this category was encouraged through the year as management explored using the data to help identify areas of concern and distribute staff across the hospital. Although this category took up the majority of the incidents, most other categories did also see a substantial increase in the number of incidents recorded.

Incidents continue to be monitored by the Risk and Resilience Team and analysis fed into the relevant groups.

3.5.3 Risk Assessment

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

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

The following table provides details of the number of "high" graded risk incidents reported since 2018/19, which have increased substantially. These High / Very High graded incidents were as a result of an increase in Communication/Information Governance Incidents specifically relating to

confidential information being sent to the wrong recipent and Staffing Resource Issues where a ward was closed for period of time. Due to the incidents happening more frequently likelihood was increased and incidents were graded as High or Very High. Both issues are being monitored. To again highlight the significant increase is due to the improved compliance reporting of Staff Resource Incidents on the Datix System, although many other categories did also show an increase.

Year	No. of "High" or "Very High"Graded Risk Incidents
2018/19	4
2019/20	1
2020/21	0
2021/22	628
2022/23	684

3.5.4 Duty of Candour

The organisational duty of candour procedure is a legal duty which sets out how organisations should tell those affected that an unintended or unexpected incident appears to have caused harm or death. They are required to apologise and to meaningfully involve them in a review of what happened.

Duty of Candour Incidents	2020/21	2021/22	2022/23
Considered	**63**	**103**	**115**
Confirmed	**0**	**1**	**0**

There were no Duty of Candour incidents reported in 2022/23.

1 incident that was indentified was still under invesitigation at the time of the report being published in 2021/22, the following learning was taken from the review:

- Review and update the Duty of Candour Policy in line with Scottish Government Guidance
- Ensure PMVA Level 2 policy is being adhered to at all times with a focus to be on completion of documentation and ensuring refresher training process is being adhered to.
- Update PMVA policy to reflect the need for a risk assessment to completed as soon as refresher training is out of date rather than after 3 months.

Further information is available in the Duty of Candour Annual Report 2022/23

3.6 Enhanced Adverse Event Reviews

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

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

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

No Category 1 Reviews were commissioned during 2022/23

One Category 2 Review was commissioned during 2022/23:

- Cat 2 22/01 Misuse of Telephone Number

Cat 2 22/01 was completed within timescales and recommendations are currently underway and being monitored by the Organisational Management Team.

3.7 Training

Training Module	Number of Staff Completed	Percentage of Staff Completed	Increase/Decrease on 2021/22
Health and Safety Awareness	141	98.1%	+2%
Manual Handling	416	99.5%	+2.2%
Fire Safety	627	99.3%	+0.3%
Level 1 PMVA	108	99.2%	+22.4%
Level 2 PMVA*	212	73.8%	+1.2%
WRAP	70	72.2%	3.9%

* Compliance levels for PMVA Level 2 Refresher training were impacted by high levels of staff absence during 2022/23, plus the associated impact on staff availability and capacity to release staff to attend refresher training within the required timeframe. A compliance improvement plan was put in place in April 2023, with a target to achieve a minimum of 90% compliance by the end of September 2023.

3.8 Freedom of Information (FOI) Responses

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

During 2022/23 the Risk Management Team received four FOI requests totalling nine questions. The team provided data for all of them where it was held by our department with the exception of one which was refused to protect both the identity of staff and the integrity of the investigation process.

4. Summary

4.1 Areas of Good Practice

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

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

Areas of good practice within the risk management department include:

- Development of the Corporate Risk Register with risk owners, the risk register continues to see positive movement over the last year as a result of further control measures being implemented. High risks are now monitored monthly with a focus on reducing risks. Further development is continuing into 2023/24.
- Updated Local Risk Register work completed and now fully in use across TSH.
- Department delivered an array of training programmes across the hospital including Incident Command, Datix Training, Control Book Training and supported the negotiator training programme – all of which upskilled staff and increased our level of resilience.
- Audit from RSM completed in March 23 which focused on our incident management processes. We received positive comments from the auditors and received a ‘reasonable’ recommendation score which was the second highest score available. Work is underway to close the few actions recommended from the audit.

- Datix Incident Reporting System received many updates throughout 2022/23 including updated categories to capture better data, introduction of the staff hot and cold debrief process to Datix and updating the way staffing resource incidents are coded. Work will continue on the system throughout 2023/24 to ensure we are capturing high quality data that is useful in the management of incidents.
- Continued development within the Risk and Resilience Team including the Risk Management Facilitator achieving their NEBOSH Health and Safety qualification. They also completed other training programmes including Managing difficult conversations with HIS and NEBOSH Wellbeing in the Workplace. They continue to work closely with departments within the hospital and work with all disciplines to ensure that they have a strong relationship with risk management and learning from incidents. The role of Risk Management Facilitator has also changed over the last couple of years and is going through the Agenda for Change process. This will provide extra resilience for the department and open new avenues of work streams.
- Head of Risk and Resilience was able to build strong relationships with many external partners, embed themselves in the organisation, organisation and provide training courses covering different aspects of resilience as well as build on their skills through various courses and training programmes.
- Control Books were identified as an issue in the previous annual report. In 2022/23 over 20 staff were trained and 4 control books audited. This will make a positive impact on the future of the control book programme as audits continue into 2023/24.

4.2 Identified issues and potential solutions

The main focus for the Risk and Resilience Team in 2023/24 will be to review our Health and Safety Management System. The first step will be to recruit a permanent part-time Health and Safety Advisor with a focus on reviewing our current arrangements and how to move them forward.

There is also a vacancies within the department for the Risk Support Officer Role and Security and Resilience Trainer. Once in post this will free up time for the Risk Management Facilitator to focus on areas that require further development.

4.3 Future areas of work and potential service developments

RSM have worked with Directors and Board Members to help deliver an updated risk appetite document. Work will continue with this in 2023/24 as the Risk and Resilience Team reviews our Corporate Risk arrangements. The aim for this year is to produce a Corporate Risk Register that aligns with the strategic aims of the hospital.

A lot of progress was made on the Datix system in 2022/23 however this will continue in 2023/24 as the teams looks to optimise the Datix system and the way information is recorded, produced and analysed.

Risk and Resilience Team will continue to raise profile across hospital and continue to help the organise mitigate risk, increase resilience and learn from incidents.

5. Next Review Date

The next annual report will be submitted to the Audit Committee in June 2024.

High 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 MD 30	Medical	Failure to prevent/mitigate obesity	Major x Likely	Major x Likely	Moderate x Unlikely	Medical Director	Lead Dietitian	01/05/23	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 & AHP	Director of Nursing & AHP	01/05/23	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 & AHP	Director of Nursing & AHP	01/05/23	Clinical Governance Committee	Monthly	-
Corporate HRD 111	Reputation	Deliberate leaks of information	Major x Possible	Major x Possible	Moderate x Unlikely	HR Director	HR Director	16/05/23	HR and Wellbeing Group	Monthly	-

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	18/07/23	Corporate Governance Group	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	18/07/23	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	18/07/23	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	Major x Almost Certain	Moderate x Possible	Minor x Possible	Chief Executive	Chief Executive	18/07/23	Corporate Governance Group	Quarterly	-

		a safe and secure environment for patients and staff.									
Corporate CE15	Reputation	Impact of Covid-19 Inquiry	Extreme x Likely	Extreme x Rare	Extreme x Rare	Chief Executive	Board Secretary	01/07/23	Covid Inquiry SLWG	Monthly	↓
Corporate MD 32	Medical	Ascension of Patients	Major x Unlikely	Major x Rare	Moderate x Rare	Medical Director	Associate Medical Director	20/04/23	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	20/04/23	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	20/04/23	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	18/07/23	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	18/07/23	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	18/07/23	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	18/07/23	Security, Risk and Resilience Oversight Group	Quarterly	-
Corporate SD 54	Service/Business Disruption	Implementing Sustainable Development in Response to the Global Climate Emergency	Major x Likely	Major x Unlikely	Moderate x Rare	Security Director	Head of Estates and Facilities	09/06/23	Security, Risk and Resilience Oversight Group	Monthly	↓
Corporate SD57	Health & Safety	Failure to complete actions from Cat 1/2 reviews within appropriate timescale	Moderate x Possible	Moderate x Possible	Moderate x Unlikely	Finance & Performance Director	Head of Corporate Planning and Business Support	18/07/23	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 & AHP	Director of Nursing & AHP	18/04/23	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 & Performance Director	Finance & Performance Director	06/07/23	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 & Performance Director	Head of eHealth	06/07/23	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 Performance Director	Head of eHealth	06/07/23	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 Performance Director	Head of eHealth/ Info Gov Officer	06/07/23	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	HR Director	17/04/23	HR and Wellbeing Group	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	01/06/23	Corporate Governance Group	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 Performance Director	Head of eHealth	06/10/23	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	HR Director	Training & Professional Development Manager	01/05/23	Clinical Governance Group	6 Monthly	-

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 June 2023
Agenda Reference:	Item No: 10
Sponsoring Director:	Director of Nursing and Operations
Author(s):	Senior Nurse for Infection Control
Title of Report:	Infection Prevention & Control Report
Purpose of Report:	For Noting

1. SITUATION

The Clinical Governance Committee receives an annual report on Infection Prevention and Control activities.

2. BACKGROUND

It was agreed that the Board would receive a brief exception report at each meeting to highlight any new issues out with the annual reporting cycle. This report highlights by exception the infection prevention and control activity for the period April and May 2023.

3. ASSESSMENT

3a) Covid Infection:
Within the April and May 2023 period, there have been five cases of covid within the patient cohort. This compares favourably against 32 cases in the previous Board exception report for the period February and March 2023.

3b) Spring Booster Vaccination
Two spring booster vaccinations were administered to patients over the age of 75.

3c) Infection & Prevention Control Group
The Infection & Prevention Control Group has met on two occasions since the last exception report. There are no areas of concern to note and no issues that required escalation to the Infection Control Committee.

3d) **National Guidance**

- DL (2023) 11 “Withdrawal of the coronavirus (Covid19):

  Extended use of facemasks and face coverings guidance across health and social care, and the unpausing of ventilator associated pneumonia (VAP) and bacteraemia surveillance” , advised that from the 16.05.2023 there will be no requirement for staff to routinely wear facemasks. They are still required as per chapter 2 (transmission based precaution) of the Scottish National Infection Control Manual.

The State Hospital adopted this from the 16.05.2023.

- Covid-19 information and guidance for social, community and residential care settings – version 2.7 (24.05.2023) and Covid-19 guidance for prison settings – version 2.5 (24.05.2023).

The IPCT team are currently reviewing these two sets of guidance.

4. RECOMMENDATION

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

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	To 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 June 2023
Agenda Reference:	Item No: 11
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 April 2023 until 31 May 2023.

	Admissions & Acute	Treatment & Recovery	Transitions	ID	Total
Bed complement	24	48	24	24 (includes 12 surge beds)	120 (+ 20 additional unstaffed beds)
Beds in use	23	47	22	15 (includes 1 MMI patient still to move)	107
Admissions	4	0	0	0	4
Discharges/Transfers	2	4	0	0	6
Bed occupancy as at 31/05/2023	95.8%	97.9%	91.7%	62.5% (all beds) 125% (ID beds)	89.2% (available beds) 76.4% (all beds)

Please note that in total there were 107 patients as of 31 May 2023, within this number 14 patients are under the care of the Intellectual Disability Service (the service is currently 2 patients in excess of their 12 patient allocation).

14 patients have been identified for transfer from TSH and 7 have been fully accepted for transfer.

There are no patients at TSH under the Exceptional Circumstances clause.

b) TSH Contingency Plan

All referrals to TSH are triaged by the Associate Medical Director and are discussed and allocated at the Patient Pathway Meeting. The allocation of referrals to a specific Responsible Medical Officer (RMO) and clinical team is agreed at the Patient Pathway Meeting and is based upon a number of factors including bed availability, clinical activity and any relevant security information. Requirements and timescales for pre-admission assessments are set out in State Hospital policy CP14 'Referrals Policy and Procedures'. If there is a requirement to enact bed contingency planning as a result of any pending admission, this will be triggered through the Patient Pathway Meeting. The contingency involves use of the surge beds in the ID service. Depending on the needs of any patient identified for a move to Iona 2 or 3, this will either be on a 24 hour basis or overnight only with a return to their original ward during the day. All patients will remain under the care of their existing clinical team. Use of the contingency measure will be monitored weekly via PPM and monthly via CGG; and reported to the Board in this paper.

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. These were requested by Scottish Government. A copy of the weekly bed report across the Forensic Network is attached dated 05/06/23 – see below. The Orchard Clinic has temporarily reduced its capacity by 7 beds for urgent repairs.

05.06.23.xlsx

3 ASSESSMENT

The current bed situation within TSH is tight because of the new clinical model but manageable. 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.
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

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 June 2023
Agenda Reference:	Item No: 12
Sponsoring Director:	Medical Director
Author(s):	Head of Corporate Planning and Performance Consultant Psychiatrist
Title of Report:	Clinical Model Closing Document
Purpose of Report:	Update Project Oversight Board

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 progressed throughout 2022/23. A project plan was developed to implement the move to the Clinical Model. A Project Team was established to deliver the implementation of the Clinical Model with oversight through the Project Oversight Board.

The implementation of the project is near completion. All significant work strands are at an advanced stage or completed. Patients have been moved to the services they have been aligned to. The Leadership Structure is being implemented. The clinical teams and services are currently in a period of stabilisation and risk assessment. It is expected that the 'go live' date for services to be fully operational will be established soon. This is awaiting an agreement on the model for activity with the service leads, and assurance that services are stabilised and assessment of risk is fully understood.

This paper informs the Board of progress and next steps for each work strand. It also closes the project implementation phase of the Clinical Model and seeks to move this into a business-as-usual approach.

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 that 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. The Board have received regular updates since implementation commenced. This paper is a project closure paper for the Board.

3 ASSESSMENT

As the implementation phase of the project has ended, project implementation activities and processes have included:

- The Clinical Model Short Life Working Group have met monthly throughout the project, their last meeting was 23rd May 2023. The group has been stood down and any further communication via e-mail updates.
- The Clinical Model Project Oversight Board have met monthly, their last meeting was the 6th June 2023 and they will meet together with the new Clinical Model Oversight Group to agree 'go live 'date prior to standing down.
- The Project Group have met weekly to progress project planning and management and will continue until 'go live ' date.
- The issues log, risk register and associate project management information have been completed.
- The Project Plan was updated regularly and the most recent version attached for information (Appendix 1).
- Monthly Flash Reports from April and May are attached as appendixes 2 and 3. A final Flash Report for June will be produced and circulated via usual routes.
- The Interim Leadership Structure is in place and initial meetings of the Clinical Model Oversight Group and the Service Leadership Teams have taken place.

Clinical Guidance

Clinical Guidance Groups were formed and have provided a final draft of the clinical guidance for each of the clinical sub specialities. The Clinical Guidance documents that have been developed by teams are now contained within an overarching document that was completed during their final meeting on Monday 5th June.

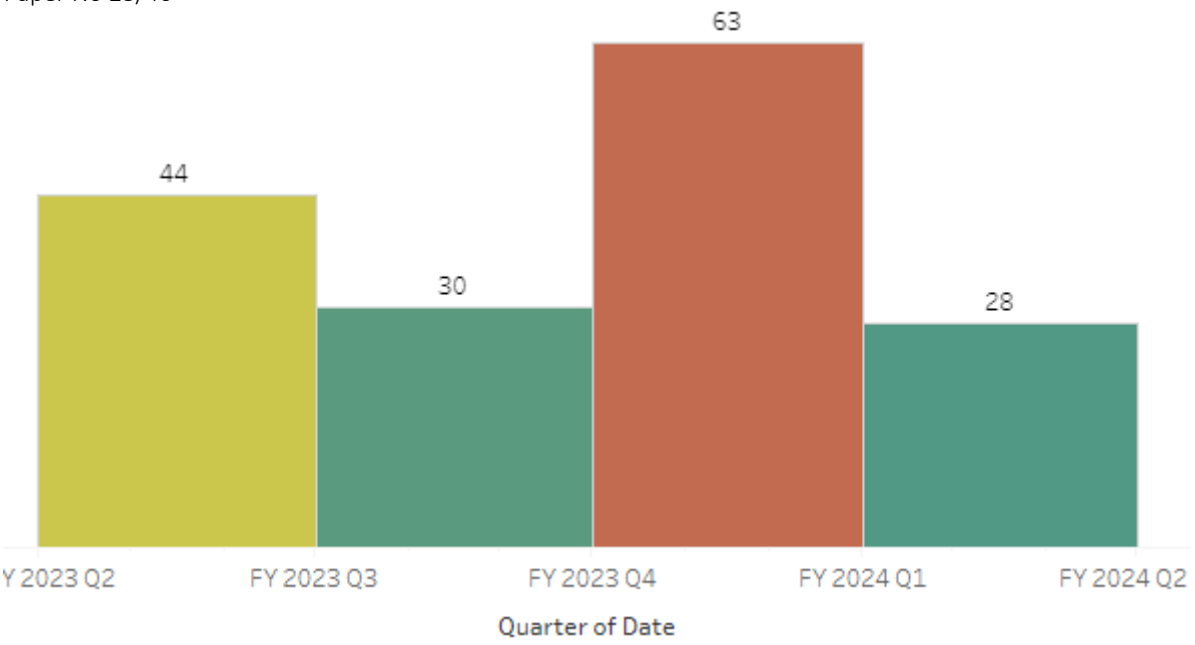
Next Steps:

The Project Oversight board are asked to agree final changes to the Clinical Guidance that include the model for activity. Responsibility for reporting will be through the service leadership teams to the Organisational Management Team (OMT) and Clinical Governance Group (CGG).

Patient Movement

Initial patient moves took place in March, however Covid related infections stalled the further planned moves later in March and April. As a result, re-planning for the moves was carried out and the patient moves were finally completed on Monday 22nd May. In total 74 patients moved –68.5% of the current patient population, a significant change for staff and all patients. At the end of the patient moves, a bed state within the hospital was completed to ensure departments could update their records. This practice will continue weekly to ensure clinical teams are aware of available beds are for movement and admissions.

A review was carried out of the incidents recorded on Datix that would indicate deterioration of mental state and escalation of violent behaviours (categories of behaviour, assault, attempted assault and self harm) over the period of the moves. Analysis reveals there was no increase in these metrics. Comparing data for the above categories of incidents over the 4 quarters revealed that Q4 22/23 was higher than during the moves, Q1 23/24. The Table below shows that over this period (Q2,Q3,Q4,Q1) there were 165 incidents, in total with 28 over the Q1 period of the moves.



To understand any learning that may inform future patient movement, a questionnaire was developed for staff to provide feedback concerning the patient moves. There was a very low response rate, less than 5%. Feedback was obtained from patients via a discussion with the Patient Partnership Group. Patients there offered positive feedback around patient moves and felt that despite a few minor setbacks that it had been managed well. Initial learning from the moves has revealed that a checklist for vacant rooms could be included in ward checks to ensure the rooms are fit for purpose.

Next Steps:
Within the newly configured services, there will a period of stabilisation and assessment. Where possible gradual stand up of the new services with a final 'go live' date where there will be an expectation that service will work to implement the Clinical Guidance. The Clinical Model Oversight Group and weekly Patient Pathway Meetings will have ongoing responsibility to identify any further patient movement and to ensure vacant beds are in admissions. Bed state to be updated weekly. A checklist for assessing vacant rooms will be developed by the Clinical Model Project Team and passed to the SCN's to implement.

Contingency Planning

A Bed Contingency Planning Group was established in November 2022 to develop a bed contingency plan for Major Mental Illness patients. As a result of movement to the Clinical Model, TSH may exceed the bed capacity within the eight MMI wards. Requiring the use of additional capacity within the ID service. The bed contingency plan will need to be implemented when the number of MMI patients is above 95, allowing for 1 MMI bed being available at all times for emergency MMI admissions. Options were reviewed by the group and a preferred option identified for the bed contingency plan. The initial bed contingency option that was preferred by the group was for a MMI patient to 'board' in the Intellectual Disability Service overnight. A SOP was developed , however on review of this was felt to be logistically difficult to implement. Further review was carried out and an agreement that patients boarding in the ID service would be considered on a case by case basis with the exact model of care to reflect patient needs and fit with the ID service.

Next Steps:
A standard operating procedure (SOP) to be developed for MMI contingency patients to receive day and night care in the ID service. This will include the criteria for patient to be considered for this approach and the process for identifying the model of care for each of these patients. Clinical Model Oversight Group to manage this process.

Activity Planning

The implementation of the new Clinical Model offers the opportunity to reconsider how activity is delivered at TSH, and how staff and environmental resource is best utilised. There is an expectation that Activity Planning would be an integral aspect of the clinical guidance and clinical model implementation.. With changes to the timetable, the ability to track individual activity and monitor how closely this aligns to activity goals is now available. The Activity Oversight Group have developed a template to support the consideration of activity across the four services. Each service has been asked to consider how activity will be delivered as part of the operating model for the services.

Next Steps : -
The new Service Leadership Teams and the Clinical Model Oversight Group both have roles on planning and co-ordination of activity. Templates to be returned to AOG and understanding of what the expectation of activity for each service delivery will look like. KPI's for activity to be developed with the services. Activity to be written into the Clinical Guidance document to enable finalisation of these. AOG to monitor the activity provision in each service as part of its ongoing work.

Communications

Communications plan has been completed. Internet page will continue to be available to staff which will host Clinical Guidance Document.

Next Steps
Final staff bulletin will be issued with June Flash report to signal to staff the completion of the project and inform of service stand up dates. Project Team will attend PPG in June to engage patients in next steps for the Clinical Model.

Workforce

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.

Next Steps:
Any new or emerging issues will go to Workforce Governance.

Service Leadership

The Introduction Leadership Model has been developed. This leadership structure will support the operationalisation of the model. In summary, an Oversight Group, chaired by Dr Duncan Alcock and Josie Clark, will provide a forum for oversight of the model and individual Service Leadership Teams has been established for each service.

Next Steps
The Introduction Leadership Model will take over full responsibility for reporting on the services as part of business as usual approaches.

Project Management Approach
The Project structure that was established to plan and implement the Clinical Model will be stood down at the end of June. The Project Initiation Document, associated papers, agendas, Flash Reports, Issues Log, Risk Register, DPIA and EQIA will be held on file. The intranet page will remain open.

Benefits realisation
The overall aim of the Clinical Model Project was to safely transition from the current service model to the new Clinical Model by the end of financial year 2022/23. The project sought to deliver the following aims and achieve the outcomes below. Following completion of the project, these will be tracked through the Clinical Governance Group.

The delivery aims are:

- More tailored security based on risk and clinical presentation, aligned with the least restrictive practice principles
- A sense of progression for patients through their clinical care journey in high security
- Streamlined integration between sub specialty wards and the Skye Centre, enabling best use of resources to support physical health, therapeutic activity and treatment goals
- Meeting the ID specific patient need through a more tailored and specialised environment. This involves distribution of patients across 2 wards rather than 1 to improve the therapeutic milieu.
- Improved clinical case mix, with admissions accommodated in specified wards
- The ability for staff to specialise in sub specialty areas of care and practice

Outcomes to be achieved are:

- An enhanced treatment environment with a more tailored and individualised approach
- Effective use and deployment of available resources
- Increased patient activity for the betterment of their physical health
- Feeling of progression for patients
- Management of patients with similar risks together with adequate staffing levels
- Staff feeling of improved safety within the workplace
- More positive recognition of staff and the support available to them

Next Steps
Clinical Governance Group will track the achievement of outcomes above. This will be through monitoring the compliance with the Clinical Guidance and the ongoing evaluation of the model. OMT will have oversight of the service management and implementation of this.
Issues will be escalated to CMT where required.

3 RECOMMENDATION

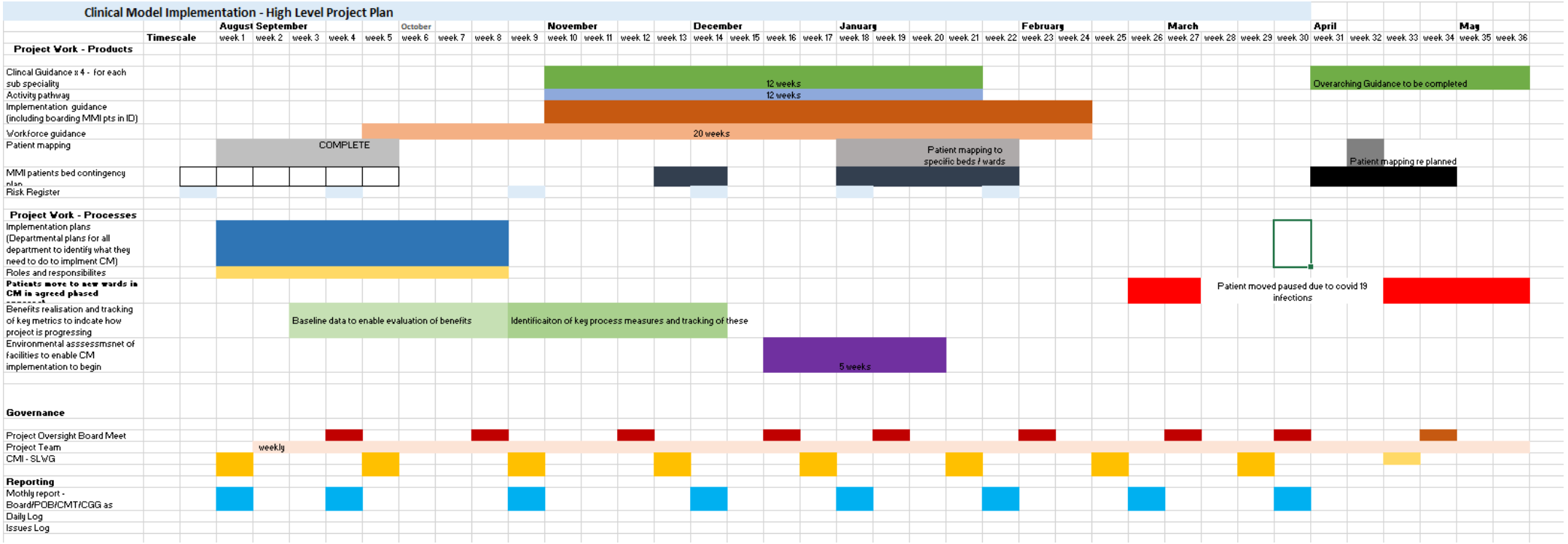
Board members are asked to:

- Note the contents of the attached documents.
- Discuss the implication of these for TSH.
- Agree the closure of the Clinical Model as a Project.

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. ϒ There are privacy implications, but full DPIA not needed ϒ There are privacy implications, full DPIA included

Appendix 1: Project Plan V5 April 2023



Appendix 2: April Flash Report

Clinical Model Flash Report – April 2023

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 May 2023.

Clinical Model Activity in April 2023:

- Clinical Guidance Task and Finish group have met to progress the overarching guidance.
- Patient moves restarted on 26th April following pause due to increase Covid
- Week by week planning in place for patient moves with go/no go criteria developed
- Contingency Plan reviewed and SOP developed, however there may need to be flexibility in which option is used depending on patient needs
- Interim Leadership approach continues to be developed

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 May 2023:

- Patient moves to continue throughout May.
- Complete work on Contingency Plan and agree criteria for patients to be considered.
- Establish Interim Leadership Teams
- Agree final version of Clinical Guidance Documents and overarching Guidance
- Agree approach to activity across all services.

Planned Meetings in May 2023:

- Clinical Model SLWG
- Clinical Model POB
- Task and Finish Group for Guidance 01/05/23

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:

- Complete patient moves, finalise contingency plans, complete clinical guidance, stand up leadership groups and establish services.

Contact Details:

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

Appendix 3: May Flash Report

Clinical Model Flash Report – May 2023

Successful implementation is a shared responsibility.

Aim of Report:

The Clinical Model describes how clinical care is structured and delivered. The implementation stage for the new Clinical Model, is nearing completion. Patients are now in the services they have been aligned to. TSH clinical teams are in a period of stabilisation and risk assessment. The 'go live' date for the services to be fully operational will be set soon

Clinical Model Activity in May2023:

- Patient moves were completed
- Clinical Guidance Task and Finish group have met to progress the overarching guidance, this is now nearing completion.
- Contingency Plan reviewed and agreed that a case by case option is used depending on patient needs. Process for implementation, criteria for consideration of patients and trigger points to be developed.
- Interim Leadership Oversight Group have met and hand over from Project Group to this group is planned

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 June2023:

- Complete work on Contingency Plan
- Establish Service Leadership Teams
- Agree final version of Clinical Guidance Documents including the approach to co-ordination of activity
- Host final Project Oversight Board and hand over to CGG, OMT, AOG
- Agree a final 'go live' date with Leadership Teams

Planned Meetings in June 2023:

- Clinical Model POB
- Task and Finish Group for Guidance 01/05/23

Key Project Milestones:

To deliver the Clinical Model, the following Key Planning Elements have been 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:

- Finalise contingency plan approach, complete clinical guidance, stand up leadership groups and establish services, agree 'go live' date.

Contact Details:

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

Paper No. 23/47

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 June 2023
Agenda Reference:	Item No: 13
Sponsoring Director:	Medical Director
Author(s):	Head of Clinical Quality
Title of Report:	Clinical Governance Annual Report 2022/23
Purpose of Report:	For Decision

1 Situation

The attached Clinical Governance Committee Annual report outlines the wide range of activity overseen by the Committee during 2022/23. The stock take also includes the Committee's Terms of Reference, Reporting Structures and Work Programme.

2 Background

Each year the committee undertakes a review of clinical governance arrangements, consisting of:

- A review of reporting structures within the hospital.
- A review of the committee's work programme for forthcoming years.
- A review of the committee's terms of reference.
- An annual report summarising the work of the groups and departments that report to the Clinical Governance Committee.

3 Assessment

Governance Reporting Arrangements
A diagram to show how each group within the hospital reports and escalates any issues.

Terms of Reference
The Committee's Terms of Reference are subject to annual review.

Programme of Work
The programme of work sets out the topics that will be presented to the committee over the coming months.

Clinical Governance Committee Annual report
The report summarises the work of the Clinical Governance Committee and highlights particular areas of good practice along with matters of concern that have been discussed throughout the year.

4 Recommendation

The Board is asked to approve the Clinical Governance Committee Annual Report, as demonstrating that the committee has met its remit and terms of reference during 2022/23.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	The annual report supports the Quality Strategy within the hospital
Workforce Implications	The various reports throughout the year would include any issues
Financial Implications	The various reports throughout the year would include any issues
Route To Committee/Group Which groups were involved in contributing to the paper and recommendations	Clinical Governance Committee
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

THE STATE HOSPITALS BOARD FOR SCOTLAND

CLINICAL GOVERNANCE COMMITTEE ANNUAL REPORT

1 April 2022 – 31 March 2023

1. Introduction

The State Hospital, like all NHS organisations, has a statutory responsibility to establish clinical governance arrangements to ensure continuous improvement in the quality of care and treatment provided to patients. The national requirements for clinical quality have been the subject of substantial guidance, from the *Clinical Governance and Risk Management Standards* published by NHS Quality Improvement Scotland (NHS QIS) in 2005, to *Better Health, Better Care*, published by NHS Scotland in 2007, the Scottish Government's publication of the *Healthcare Improvement Strategy for NHS Scotland* in 2010 and subsequently through the NHS Healthcare Improvement Scotland *Making Care Better – Better Quality Health and Social Care for Everyone in Scotland 2017-2022.* The 5 main strategic priorities are:

1) Enable people to make informed decisions about their own care and treatment.
2) Help health and social care organisations to redesign and continuously improve services.
3) Provide evidence and share knowledge that enables people to get the best out of the services they use and helps services to improve.
4) Provide and embed quality assurance that gives people confidence in the quality and sustainability of services and supports providers to improve.
5) Make best use of all resources.

The underlying principle of effective clinical governance is that systems and processes provide the framework for patients to receive the best possible care. This report provides an overview of the work of the Clinical Governance Committee during 2022/23 and examples of good practice and matters of concern.

2. Committee Chair, Committee Members and Attendees

Committee Chair
Cathy Fallon, Non-Executive Director

Committee Members
Stuart Currie
David McConnell

Attendees
Brian Moore, Chair of The State Hospitals Board for Scotland
Gary Jenkins, Chief Executive
Prof. Lindsay Thomson, Medical Director
John Marshall, Head of Psychological Services (until May 2022)
Elizabeth Flynn, Head of Psychological Services (from February 2023)
Monica Merson, Head of Corporate Planning and Business Support
Karen McCaffrey, Director of Nursing and Operations
Robin McNaught, Director of Finance & eHealth
Dr Khuram Khan, Chair, Medical Advisory Committee
Sheila Smith, Head of Clinical Quality
Margaret Smith, Board Secretary

The Committee can decide to invite the Board Chair to sit as a member of the Committee for a meeting, should this be required for quorate decision-making.

3. Meetings during 2022/23

During 2022/23 the Clinical Governance Committee met on four occasions, in line with its terms of reference. Meetings were held on:

- 12 May 2022

- 11 August 2022
- 10 November 2022
- 9 February 2023

Attendance of members at the meetings can be found in appendix 1

4. Reports Considered by the Committee During the Year

4.1 12 Monthly Internal Governance Reports

Fitness to Practice
The Committee received a report in relation to Fitness to Practise at its May 2022 meeting. The reporting period covered was 1 April 2021 - 31 March 2022. The report was submitted to the Committee for information in respect of the process for monitoring professional registration status at The State Hospital thus providing assurance that all relevant staff hold current professional registration as appropriate. During 2021/22, there was one lapse in NMC registration. This is an increase on the previous year, where there were no lapsed registrations. There was also one GMC Registration that lapsed resulting in the process being followed.

Infection Control
The infection Control Committee report was received and noted at the May meeting, covering the period 1 April 2021 - 31 March 2022. The report highlighted the work undertaken by the newly recruited Quality Improvement Facilitator to improve compliance with hand hygiene practices. This piece of work looked at audit tools and how to make them more relevant to the ward environment. Results were very positive and sitting above 90%. Seasonal flu vaccination uptake for staff had reduced but it was believed to be as a result of people taking covid and flu vaccinations together in the wider community and there is no requirement for staff to inform the hospital if this is the case. DATIX was noted as an area of concern, specifically around laundry. Work was being done with Risk Management and the Laundry and Housekeeping Manager to look at a different format of managing laundry, linking with Lead Nurses and Senior Charge Nurses to make them more accountable at ward level. This will hopefully see an improvement in this area. Safe management of linen has also been added to the induction for student nurses. Online tools have also been used to create innovative ways for infection control training.

Research Committee/Research Governance and Funding
In May 2022 the Committee received and approved the 2021/22 Research Committee Annual Report. The reporting period covered was 1 April 2021 - 31 March 2022. The main areas of focus within the report were the range of research activity, its dissemination undertaken by The State Hospital staff over the period of 2021/22, and the implementation of research findings into practice. The report also provided details of the annual Forensic Network Research conference. As requested by the Clinical Governance Committee, the report also specifically addressed additional ways to monitor performance and highlight the work conducted to define the priority areas for research with Scottish Forensic services. The Committee noted that this was a very thorough report and it was good to see the number of research projects undertaken; the Committee looks forward to seeing the patient perspective within next year's report.

Medicines Committee
The Medicines Committee annual report was submitted to the Clinical Governance Committee in May 2022, covering the period 1 April 2021 - 31 March 2022. The Committee approved the report and commended the service for being able to work within budget. The key activities over the 12 months included: maintaining supply processes to the wards during Covid-19 challenges; continuing with vaccination programme for staff and patients in line with national guidance; ensuring all patients have a regular review of their mental health and physical health medicines. Pharmacy provide reports for all CPA meetings (100%); policy and prescribing guidance updates; a significant range of clinical audit projects including Consent to Treatment

Adherence, Use of Psychotropic PRN (as required) Medicines and Lithium monitoring and the proactive work around medication incidents.

The Committee formally thanked the Lead Pharmacist, on the occasion of her retirement, for more than 20 years' service to the hospital.

Patient Learning Annual Report

At the May 2022 meeting, the Patient Learning annual report was presented, covering the period 1 January 2021 - 31 December 2021. The Committee noted the progress that had been made and acknowledged the planned future developments that are detailed within the report. The report notes that during 2021 learning opportunities for patients had continued to be impacted by the COVID pandemic. However, positive progress had been made in a number of areas of patient learning within The State Hospital: the curriculum framework continued to provide access to a broad range of nationally recognised qualifications and accredited national units; learning opportunities, although limited during year, ranged from entry level through to further and higher education and included clear progression pathways. A total of 64 patients engaged in formal learning programmes; 33 formal qualifications were attained within 2021 and during 2021 a key focus was to re-establish group-based and subject specific learning across the core skills programmes.

Duty of Candour

The fourth annual report for Duty of Candour was received and noted at the August 2022 meeting. The report covered information on the policy, training that had been implemented across the site as well as the governance and monitoring arrangements. For the period 1 April 2021 - 31 March 2022 the Risk Management Department forwarded 103 incidents for consideration by the Duty of Candour Group, up from 63 in the previous year. One of the incidents fulfilled the criteria for Duty of Candour, i.e. an unintended or unexpected act or incident that resulted in death or harm, as defined within the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016 and did not relate directly to the natural course of a person's illness or underlying condition. At the time of the report being presented at Clinical Governance Committee, the incident was still under investigation. Once the report is published it will be shared with the relevant persons and any required changes implemented.

Patient Safety

In August 2022 the Committee received and noted the Patient Safety Report covering the period 1 July 2021 - 30 June 2022. The four principles remained: Communication; Leadership and Culture; Least Restrictive Practice and Physical Health. Key pieces of work included: the prioritisation of the change ideas from the Essentials of Safe Care driver diagrams; the introduction of the Learning into Practice sessions for staff; the re-introduction of the Quality and Safety visits to various wards and departments within the hospital and the continuation of clinical pause within the hospital that allows clinical team members to come together to reflect on whatever the situation is and then formulate a plan on how to manage it.

Mental Health Practice Steering Group

At the August 2022 meeting, members received and noted the report from the Mental Health Practice Steering Group. The report covered the period 1 January 2021 – 30 April 2022. Key areas noted within the report included: the standards and guidelines that had been reviewed by the Group; monitoring data for the psychological service; completion of risk assessments; the monitoring of grounds access in our patient population; work being undertaken with regards to clinical outcomes; the pre-admission specific needs QI project; review of the CPA process and stakeholder feedback through the 'What Matters to You and Patient Partnership Group. The Committee also 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.

CPA/MAPPA
At the November 2022 meeting the Committee noted the report covering the period 1 October 2021 - 30 September 2022 and supported the future areas of work. For the fourth consecutive year, 100% of transfers were managed through the CPA process during the reporting period. The report identified a number of key areas in relation to Multi-Disciplinary CPA attendance, Patient and Carer Involvement and Strategic Engagement and Representation. During the review period no patients had been identified as potentially meeting the MAPPA risk of serious harm category, however all patients remain under consideration in this regard and consultation takes place with the relevant MAPPA Co-ordinators as appropriate. Areas of good practice included patient involvement in the process with 77% attending meetings and Advocacy attending 81%. Inter-agency working was also highlighted with receiving services being well represented in transfer/discharge CPAs.

Child and Adult Protection
The Committee received and noted the report in November 2022 that covered the period 1 October 2021 - 30 September 2022. The report highlighted key areas of work that included key achievements in the areas of keeping children safe and adult support and protection. Other key areas included: updating the Keeping Children Safe Policy in line with newly published guidance; the submission of The State Hospital Corporate Parenting Plan 2021-23 and the ongoing updating and development of training materials to ensure they provide up to date information and practice guidance. The Social Work Team also offered to provide additional training slots and development sessions to staff who may find it difficult to attend the regularly scheduled inputs.

Physical Health Steering Group
In November 2022 the Committee received and noted the 12 month rolling report from the Physical Health Steering Group covering the period 1 October 2021 - 30 September 2022. The report noted the developments and progress made in the five key strands for which the Physical Health Steering Group had responsibility. These related to Primary Care (including long term conditions); Physical Activity; Nutrition and Weight Management; Food, Fluid and Nutrition and National Guidelines and Standards. Quality improvement activity included the further development of patients undertaking the Level 4 Sports Leadership course allowing them to become Sport Volunteers; the change from a 90 minute target to a 150 minute target to bring us in line with World Health Organisation guidance and the appointment of a new General Practitioner who is able to provide venesection and minor surgery on our patient group, thus reducing the need for external clinical outings.

Rehabilitation Therapies Service
In November 2022 the Committee noted the report covering the period 1 October 2021 - 30 September 2022 and endorsed the future areas of work and service developments contained within it. The report provided a summary of the key areas of work that included: updates on the various staff groups that are included in the AHP service; leadership development within the service; staff and team development; the Nu 2 U Charity Project that has allowed a patient run shop to be opened with clothes that patients can purchase for a nominal cost; plans for training staff in occupational formulations and the introduction of the RiO planned timetables that allows staff to see the planned activity for their patients.

Person Centred Improvement Service
The Committee warmly received and noted the Person Centre Improvement Report at its November meeting. The report covered the period 1 November 2021 - 31 October 2022. Key areas of work included: facilitation of the ‘What Matters to You’ initiative; development of a new volunteer driver scheme; supporting the development of the ‘Nu 2 U’ charity shop; successfully bidding for capital funds for renovating the Family Centre garden; supporting patients to engage in the Quality and Safety visits; supporting PPG in a number of activities including developing a process to ensure that patient experience influences the Clinical Model implementation plans; the permanent implementation of Family Centre visiting; the completion

of ‘Talking Mats’ training by staff and the transfer of online volunteer mandatory training modules to hard copy in response to volunteer feedback.

Clinical Governance Group
At the February 2023 meeting the Committee received and noted the 12 monthly report from the Clinical Governance Group covering the period 1 January 2022 - 31 December 2022. The report provided a summary of the work of the Clinical Governance Group over the past 12 months. As well as overseeing the reports that go to the Clinical Governance Committee other key pieces of work included: monitoring the realistic medicine action plan; receiving updates on the Clinical Care Policy; receiving updates on the hospital leadership team tableau dashboards; receiving updates from the Activity Oversight Group; commenting on the digital inclusion updates; receiving updates on the Clinical Model as it progresses; monitoring the actions from the Triangle of Care assessment. The areas of future work include: supporting the implementation of the clinical model, including preparation of guidance for the four ward types, patient flow, model fidelity and development of measures to monitor the model; oversight of the implementation of the QI Activity Project to ensure activity within the patient’s objectives are reflected in the activities delivered to the patient; exploring the effects of staffing shortages on clinical care; monitoring the implementation of the Clinical Care Policy, including changes in practice and ensuring we remain focussed on quality improvement through a number of initiatives including Realistic Medicine and TSH3030.

Psychological Therapies
At the February 2023 meeting the Committee noted the Psychological Services report covering the period 1 January 2022 - 31 December 2022. The report highlighted individual, group work and consultation activity which was lower than pre pandemic levels. Key performance indicators, such as patients engaged in psychological treatment and patients commencing psychological therapies in less than 18 weeks from the referral date were reported on and found to be generally within normal variation. Staff vacancies have affected attendance at CPA meetings. Several new staff members have joined the department which will contribute to organisational priorities such as the physical health agenda and facilitation of reflective practice. Future developments included: a programme of work with clear objectives and outcomes that will involve the Health Psychologist; the completion of a neurodevelopmental pathway with an aligned training plan; Trauma- informed care training provided to State Hospital staff; implementation of Moving Forward Making Changes in collaboration with the National Steering Group and implementation of a yearly planner of projected group therapy delivery including planned start and end dates to aid treatment planning.

4.2 Standing Items Considered by the Clinical Governance Committee during the Year

Covid-19
In March 2020 restrictions were placed on the hospital in relation to the national outbreak of Covid-19. In response to this a paper was presented at all four meetings during 2022/23. The paper provided updates on the number of patient tests that had been required due to symptoms or close contact with another patient testing positive; the number of patients that had tested positive; information on any outbreaks; the development of clinical care support documentation in partnership with NHS Lanarkshire; new treatments for Covid-19; the standing down of the general medical ward within The State Hospital in October 22; the re-introduction of visiting arrangements and enhanced surveillance reporting through STAG and then CMT. It was agreed at the February 2023 meeting that there was no requirement for this to continue as a standing agenda item and going forward this information will come through the Infection Control Annual Report.

Learning from Complaints
The quarterly Learning from Complaints report was considered and noted by the Committee at every meeting. Actions arising from all complaints are included within the report to share the learning which enables the organisation to develop services which take cognisance of

complaint outcomes. The report is based on the two stage model that enables complaints to be handled either locally by front line staff, allowing for *Early Resolution* (Stage 1) within 5 working days, or for issues that cannot be resolved quickly or are more complex, by *Investigation* (Stage 2) within 20 working days. The main themes for complaints during the year were staff shortages (as these resulted in patients bring confined within their bedroom for longer periods of time), staff attitude/behaviour/conduct, written/oral communication and clinical treatment (this covers a wide range of subjects including involvement in care plans and time taken to go through the grounds access process).

Learning from Feedback
The quarterly Learning from Feedback report was considered and noted at every Clinical Governance Committee meeting. These reports highlight the feedback received, encompassing concerns, comments and suggestions, (including evaluation forms) and any compliments/positive feedback received. The report noted the outcome from all feedback and any lessons that have been learned by the hospital. The Committee members were happy to see an increase in the number of compliments being received in relation to Family Centre visits.

Patient Movement Statistical Information
The Committee received and noted two reports during the year at its May 2022 and November 2022 meetings. The May 2022 report covered the reporting period 1 October 2021 - 31 March 2022 and the November 2022 report covered 1 April 2022 - 30 September 2022. These reports provided an overview of bed occupancy, area and source of admission, delay between referral and admission, admissions of young people (under 18), 'exceptional circumstances' admissions, appeals against excessive security, discharges and transfers and number of patients on the transfer list.

Incident Reporting and Patient Restrictions Report
The quarterly Incident Reporting and Patient Restrictions report was considered at every Clinical Governance Committee meeting. The report showed the type and number of incidents received through the incident reporting system DATIX, as well as all the restrictions applied to patients during the periods under review. The report provided more information of the various incidents that had occurred in relation to PAA activations; the use of handcuffs; patient seclusions; withheld mail; urinalysis results; security incidents; communication/information incidents and incidents relating to equipment, facilities and property. The Committee continue to welcome the trend graphs that are included within the report that allows them to see incidents over time.

Staffing and Care Report
The staffing and care report was presented at all the meetings during 2022/23. The reports included any challenges with staffing; including the number of times a ward had to close due to staff shortages (this would mean patients being cared for in their rooms for the duration of the shift) and the challenges the hospital has recruiting an acceptable gender mix due to the small numbers of males going into mental health nursing.

Corporate Risk Register – Clinical Update
The clinical update paper was added as a standing agenda item during 2023. This was a directive from the Board. The most recent paper at the February 2023 meeting showed that all clinical risk assessments were within their review date; HRD112 'Compliance with PMVA Refresher Training' has moved from medium to low risk. This is due to the increased compliance level for staff training (92%); updates were provided on the four high/very high clinical risks: ND71 Failure to assess and manage the risk of aggression and violence effectively – Level 3 PPE training has been completed along with Bronze Commander training; MD30 Failure to prevent/mitigate obesity – the Supporting Healthy Choices Strategy is being implemented and there are plans to start a Health Education Group in 2023 that will support patients to make healthier choices and adopt healthier lifestyles; ND70 Failure to utilise our resources to optimise excellent patient care and experience – staffing is being monitored daily

and continues to be a priority for the hospital, recruitment is ongoing with modified/closures being utilised where required and CE15 Impact of UK and The State Hospital Covid-19 inquiries on the hospital - this is a new risk that was added following CMT in December 2022. This risk has been graded high initially and will be reviewed monthly.

5. Discussion Items During the Year

Patient Activity
The discussion item was re-introduced at the August 2023 meeting with a presentation being given on patient activity.

The presentation provided an overview of the definition of activity and the importance of this, what collected data tell 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.

Clinical Model
The November 2022 and February 2023 meetings saw a presentation that provided an overview of the preparation that has gone into the successful implementation of the new Clinical Model. The presentations gave key updates on:

- the successful completion of the patient mapping exercise, with letters being hand delivered to all patients notifying them which Service they will be in at implementation.
- the benefits and intentions aimed to be achieved through the new model, such as increased patient activity, feeling of progression for patients, effective use and deployment of available resources, and an enhanced treatment environment with a more tailored approach.
- clinical guidance updates which included key treatment and recovery objectives, definition and purpose, structure, admission and transfer criteria, staffing, procedural and security guidance, activity aims, care planning and risk assessment and outcome measures / KPIs.
- work being progressed by each of the four service groups established.
- staff engagement to ensure patients, staff and carers are as well advised as possible through the delivery of a robust communication plan.
- patient engagement which was a regular topic of discussion featured at the Patient Partnership Groups.
- other key current work strands involved including the bed contingency discussions and options appraisal, hub versus service leadership discussions, collaborative work with the Activity Oversight Group and workforce guidance in development.
- intended timescales on products, processes and governance were noted.

Members thanked those involved in this area of extensive work and for the very interesting and reassuring presentation.

6. Special Topics/Items for Approval

Clinical Governance Annual Stock Take
At its May 2022 meeting, the Committee received and noted: the Clinical Governance Reporting Structures 2022-23; the Programme of Work for 2022-23 subsequent to any changes that may arise at future meetings; the Clinical Governance Committee Terms of Reference; and the Clinical Governance Annual Report 2021-22. The Annual Report summarised the work of the Committee during the financial year 1 April 2021 - 31 March 2022.

Committee Self-Assessment

This report was presented at the meeting in February 2023. As part of the Corporate Governance Improvement Action Plan, the Board requested that a self-assessment survey should be devised and conducted on behalf of the Clinical Governance Committee. Feedback included:

- Setting the Direction - responses were positive overall for the leadership role taken by the Committee.
- Holding to Account - this was one of the most positive areas for the self-assessment with most responses indicating that it was felt that the Committee steers well in terms of seeking appropriate levels of assurance. It reflected an ability to both scrutinise and challenge performance throughout; and that there is focus on the way in which the organisation discharges its duties in the delivery of clinical care.
- Assessing Risk - this was the area of the survey which drew the most negative response, with very mixed feedback. The ability of the Committee to assess risk appropriately in the context of mitigations put in place highlighted a range of views with some believing this was carried out well; and others feeling it was only adequate or inconsistent. There was a similar mix of views around consideration of future risks as well as of organisational risk tolerance.
- Engaging Stakeholders - the responses in this respect were reasonably positive as a whole, especially around setting Committee business. At the same time, responses were slightly more mixed in the way that the Committee reports on its own performance to the Board, as well as the links to relevant stakeholders.
- Influencing Culture - this drew very positive feedback with it being felt that the Committee performs very well in this respect and adds value to leadership on values and behaviours throughout the organisation.

Category 1 Review Reports

No Category 1 reviews were presented at Clinical Governance Committee during the reporting period.

7. Areas of Good Practice Identified by the Committee

- Person Centred Improvement Team continue to engage with the independent Patients Advocacy Service and Complaints and Legal Claims Officer in order to triangulate information shared by patients.
- Commendation for high level detailed Learning from Complaints report and also reflecting on the openness of the organisation in the way it handled complaints meaning that a rise in complaints received was not necessarily negative.
- The existing SOP for the Management of Suspected/Confirmed Cases was revised. This new SOP moves towards a least restrictive practice and is mirroring the practice in other establishments. The State Hospital will manage individual cases and therefore there should not be routine closures of wards through Covid outbreaks. The Senior Nurse for Infection Control will continue to review each positive case and make amendments to the SOP if required.
- The finding by housekeeping staff of secreted medication as detailed in the Incidents and Patient Restrictions Report.
- The Transfer/Discharge Care Programme Approach 100% compliance target achieved as detailed in the Annual Report.
- The significant work undertaken by the relatively new General Practitioner, and his positive impact and systematic approach in improving patient general medical care services.
- The successful memorial service held for a patient from a person centred approach as was referred to in the Learning from Feedback Annual Report.

8. Matters of Concern to the Committee

Matters of concern	Update
No matters of concern were noted	

9. Conclusion

From the review of the performance of the Clinical Governance Committee, it can be confirmed that the Committee has met in line with the Terms of Reference and has fulfilled its remit. Based on assurances received and information presented to the Committee, adequate and effective Clinical Governance arrangements were in place throughout the year.

Attendance at meetings (members)

	12th May 2022	11th August 2022	10th November 2022	9th February 2023
Cathy Fallon	X	X	X	X
Stuart Currie		X	X	
David McConnell	X	X	X	X
Brian Moore	X	X	X	X
Gary Jenkins	X	X	X	X
Prof Lindsay Thomson	X	X	X	X
John Marshall	X			
Elizabeth Flynn				
Monica Merson		X		X
Karen McCaffrey	X	X	X	X
Robin McNaught	X		X	X
Dr Khuram Khan	X		X	
Sheila Smith	X	X	X	X
Margaret Smith	X	X	X	X

X denotes attendance

The State Hospital

CLINICAL GOVERNANCE COMMITTEE

TERMS OF REFERENCE

1 PURPOSE

The Clinical Governance Committee is a standing committee of the Board and shall be accountable to the Board. Its purpose is to provide the Board with the assurance that clinical governance mechanisms are in place and effective within the State Hospital.

2 COMPOSITION

2.1 Membership

The Clinical Governance Committee is appointed by the Board and shall be composed of at least three Non-executive Board members, one of whom shall act as Chair.

The Chairperson of the Board, and the Chief Executive, shall both be ex-officio members.

The Clinical Governance Committee will have the authority to co-opt up to two members from outwith the Board in order to carry out its remit. These members will act in an ex-officio capacity.

Members:

- Stuart Currie
- David McConnell
- Shalinay Raghavan
- C Fallon (Chair of the Clinical Governance Committee)

In Attendance

- Brian Moore, Chair of The State Hospitals Board for Scotland
- Gary Jenkins, Chief Executive
- Prof. Lindsay Thomson, Medical Director
- John Marshall, Head of Psychological Services
- Monica Merson, Head of Corporate Planning and Business Support
- Karen McCaffrey, Director of Nursing, AHPs and Operations needs to be new person in post
- Robin McNaught, Finance & eHealth Director
- Dr Khuram Khan, Chair, Medical Advisory Committee
- Sheila Smith, Head of Clinical Quality
- Margaret Smith, Board Secretary

2.2 Appointment of Chair

The Chair of the Committee shall be appointed at meeting of the Board in accordance with Standing Orders.

2.3 Attendance

Members shall normally attend meetings and receive all relevant papers. All Board Members, the Chair of the Medical Advisory Committee and the Chair of the Research Committee, will have the right to attend meetings and have access to all papers, except where the committee resolves otherwise.

If attendance at the meeting is only required on a periodic basis, this should be agreed with the Committee Chair in advance. Apologies should be tendered to the Chair of the Committee via the minute secretary at least 2 working days prior to the meeting unless an exceptional event prevents this level of notice.

Where a member who is due to present a paper is not able to attend, they should ensure that another person is suitably briefed in order to deal with this item. The arrangement made should be discussed and approved by the Committee Chair.

To fulfil its remit, the group may obtain whatever professional advice it requires and invite, if necessary, external experts and relevant members of hospital staff to attend meetings. If necessary, meetings of the Committee shall be convened and attended exclusively by members of the Committee.

Others may attend the Committee on the approval of the Committee Chair.

3 MEETINGS

3.1 Frequency

The Clinical Governance Committee will meet quarterly to fulfil its remit and shall report to the Board following each meeting.
The Chair of the Committee may convene additional meetings as necessary.
The Accountable Officer of the Board may ask the Chair of the Committee to convene further meetings to discuss particular issues on which they want the Committee's advice.

3.2 Agenda and Papers

The agenda and supporting papers will be sent out at least five working days in advance to allow time for consideration of issues.

The format of agendas and papers will be in line with corporate document standards. The lead Executive for co-ordinating agendas and papers is the Medical Director.

All papers will clearly state the agenda reference, the author, and the purpose of the paper, together with the action to be taken. Cover papers should be prepared in the format set out in Corporate Document Standards, to draw out the main issues for the Committee. Annual Reports of reporting committees should follow the format set out in Corporate Document Standards.

Documents will be watermarked as Confidential, or Draft as required. Documents which are watermarked as Confidential should not be shared outwith the Committee membership. Guidance on confidentiality and openness can be sought from the Records Services Manager.

The secretary for this Committee will maintain a master file of documents, in line with Policy for Management, Retention and Disposal of Administrative Records.

3.3 Quorum

In the event of the Committee making decisions, two members need to be in attendance to be quorate.

3.4 Minutes

Formal minutes will be kept of the proceedings and submitted for approval at the next Board meeting. The Board Secretary is responsible for minute taking arrangements. The draft minutes will be cleared by the Chair of the Committee and the nominated lead Executive (Medical Director) prior to approval by the Committee and notification to the Board.

Following approval, minutes will be placed on the hospital's website.

4 REMIT

4.1 Objectives

The main objectives of the Clinical Governance Committee are to provide the Board with the assurance that clinical governance mechanisms are in place and effective within The State Hospital; and that the principles of clinical governance are applied to the health improvement activities of the Board.

Existence and effective operation of this committee will be demonstrated in continuous improvement and compliance with clinical standards, in delivery of improved services for patients, and ultimately in improved outcomes for patients as evidenced through the clinical key performance indicators reported in the Local Delivery Plan.

4.2 Systems and Accountability

- To ensure that appropriate clinical governance mechanisms are in place throughout the hospital in line with national standards.
- To ensure that clinical risks are managed in accordance with the corporate risk management strategy, policies and procedures.
- To ensure that staff governance issues which impact on service delivery and quality of service are appropriately managed through clinical governance mechanisms.
- To ensure that systems are in place to meet information governance standards.
- To ensure that systems are in place to meet research governance standards.

4.3 Safe and Effective Care

To provide assurance to the Board in respect of clinical risk management arrangements, that:

- Structures are in place to minimise potential problems such as effective risk assessment and management, incident reporting, critical incident reviews, and complaint procedures.
- Lessons are being learned from adverse events and near misses.
- Systems are in place to measure and monitor duty of candour and any lessons to be learned.
- Complaints are handled in accordance with national guidance and lessons will be learned from their investigation and resolution (including reports of the Scottish Public Services Ombudsman and the Mental Welfare Commission).
- Arrangements are in place to support child and adult protection obligations.

4.4 Health, Wellbeing and Care Experience

- To ensure that the environment supports delivery of high-quality care with a culture and appropriate mechanism to allow staff and others to raise concerns on the standard of care provided, including the performance of clinical colleagues, in the knowledge they will be addressed without detriment to themselves or prejudice to the principles of confidentiality.
- To ensure systems are in place to monitor and measure the mental health and physical health requirements of our patient population, including medicine management, psychological therapies, and rehabilitation services.
- To ensure that arrangements are in place to embed Person Centred Improvement activities, including equality and diversity issues pertinent to clinical governance.
- To ensure that care is provided by appropriately trained and skilled professionals with the competencies required to deliver the required care.
- To ensure that clinical policies and procedures are developed, implemented, and reviewed.
- To ensure that poor performance of clinical care will be identified, and remedial action taken.

4.5 Control Assurance

- To ensure that quality of clinical care drives decision making and that clinicians are involved in planning, organising, and managing services.
- To ensure that the planning and delivery of services has taken full account of the perspective of patients and the general public.
- To ensure that systems are in place to measure and monitor performance to foster a culture of quality and continuous improvement.
- To ensure that research and development programmes are initiated, monitored, and reviewed.
- To ensure a comprehensive information governance framework is in place which ensures the Codes of Practice on Openness and on Confidentiality of Personal Health Information are fully applied.

The Committee will manage its business through a workplan, agreed by the Chair of the Committee. This will ensure that the full remit is covered on a rolling basis.

5 AUTHORITY

The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

6 PERFORMANCE OF THE COMMITTEE

The Committee shall annually review and report on:

- Its own performance, effectiveness, and the level of input of members to the Committee relative to added value achieved.
- Proposed changes, if any, to the terms of reference.

7 REPORTING FORMAT AND FREQUENCY

The Chair of the Committee will report to the Board following each meeting of the Clinical Governance Committee, by presenting the minutes of the Committee.

The Chair of the Committee shall submit an Annual Report on the work of the Committee to the Board.

8 COMMUNICATION AND LINKS

The Chair of the Committee will ensure that relevant issues are shared with the Staff Governance Committee.

The Chair of the Committee will be available to the Board as required to answer questions about its work.

The Chair of the Committee will ensure arrangements are in place to provide information to the Scottish Government as required to meet their reporting requirements.

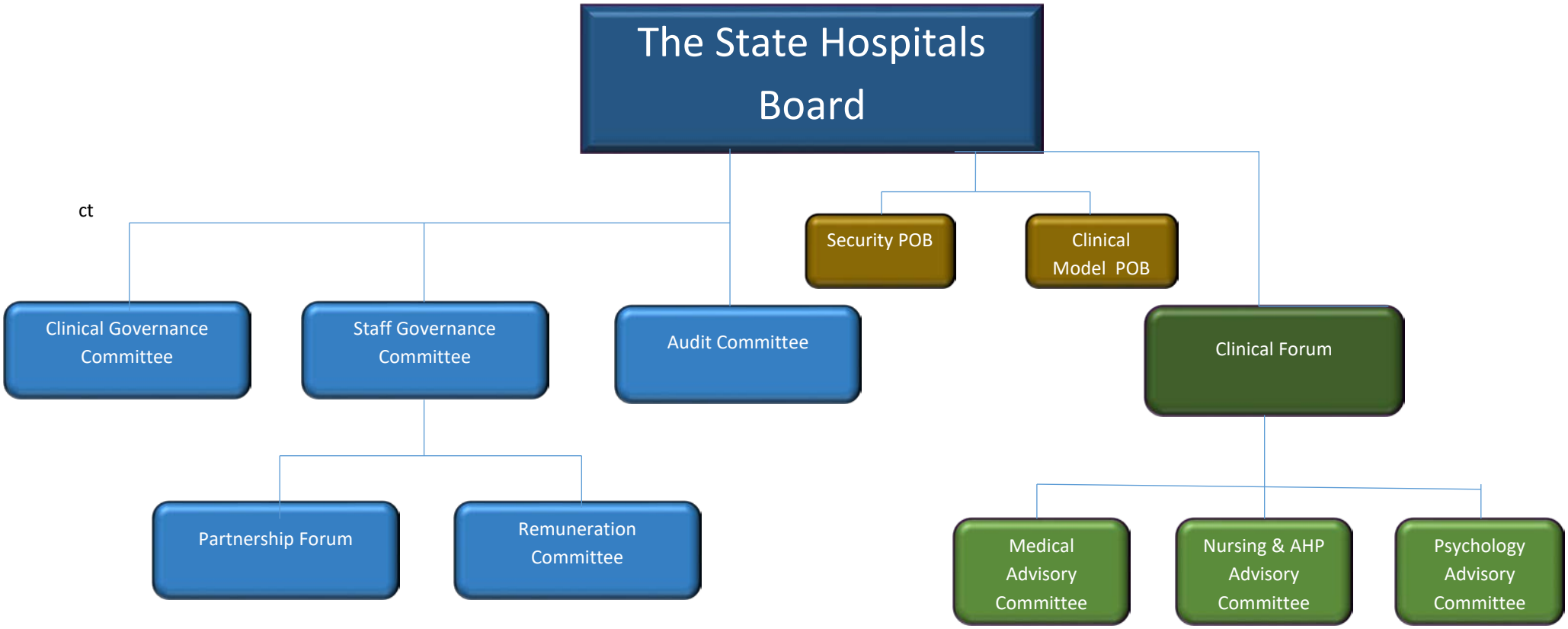
Subject to annual review.
Next revision: May 2024.

Clinical Governance Committee Programme of Work 2022/23

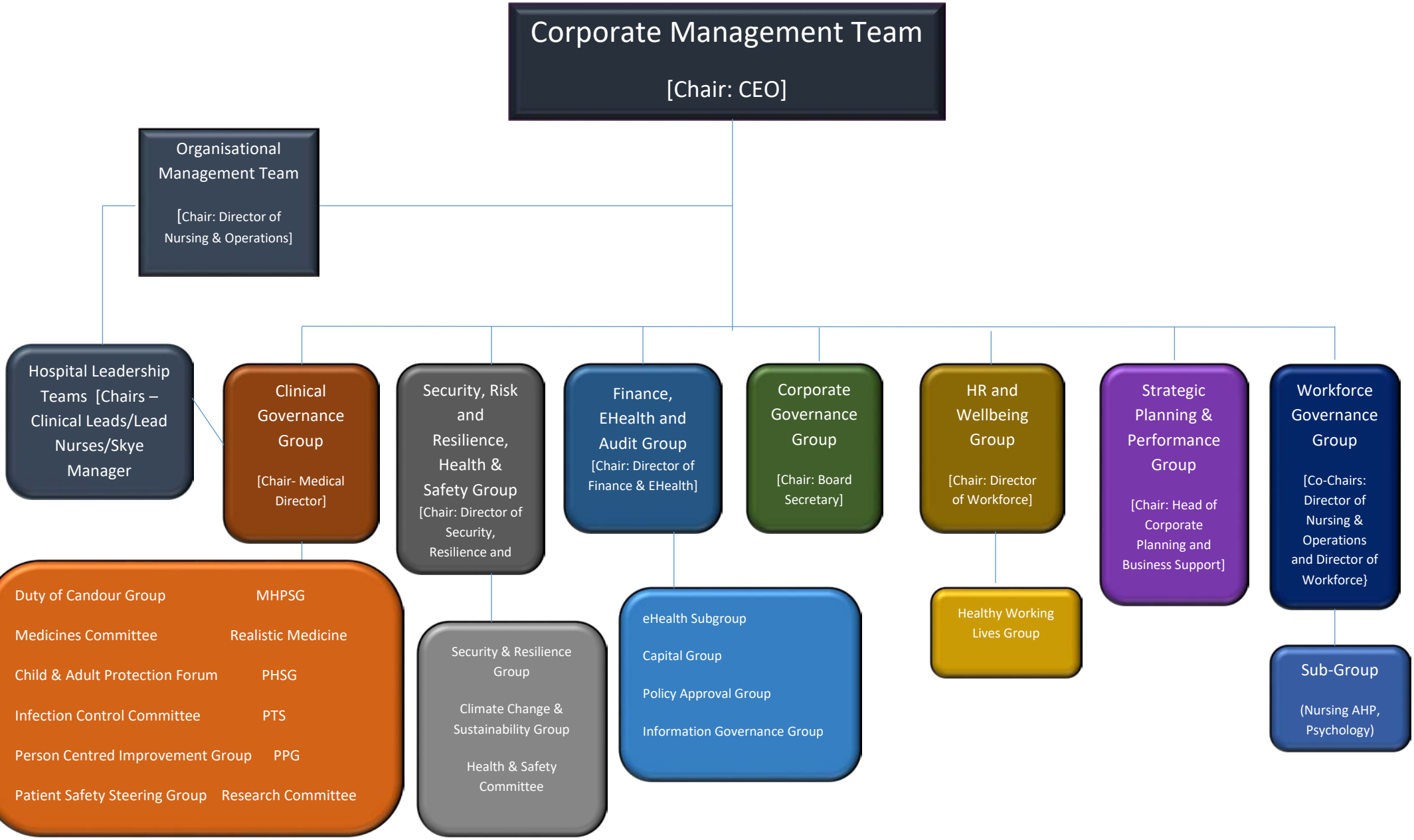
Area of review	10th February 2022	12th May 2022	11th August 2022	10th November 2022	9th February 2023	11th May 2023	10th August 2023	9th November 2023
Standing items (20 minutes)	• Minutes of last meeting • Matters arising update • NHS HIS reports as available • CAT 1/Adverse Event report as available • Learning from feedback • Learning from complaints • Clinical Model • Corporate Risk Register – Clinical Update • Incident reporting and patient restrictions • Agreement of item for discussion at next meeting				• Minutes of last meeting • Matters arising update • NHS HIS reports as available • CAT 1/Adverse Event report as available • Learning from feedback • Learning from complaints • Clinical Model • Corporate Risk Register – Clinical Update • Incident reporting and patient restrictions • Agreement of item for discussion at next meeting			
12 month Monitoring Reports (70 minutes)	• Psychological Therapies • Clinical Governance Group • Staffing and Care Report	• Medicines Committee/ Pharmacy • Research Committee / Research Governance and Funding • Fitness to Practice • Patient Movement – Statistical Report • Infection Control • Staffing and Care Report • Patient Learning Report	• Risk Register • Patient Safety Programme • Duty of Candour • Staffing and Care Report • Mental Health Practice Steering Group	• Rehabilitation Therapies Services • Physical Health Steering Group • Patient Movement – Statistical Report • Person Centred Improvement Service • Adult & Child Protection • CPA/MAPPA • Workforce Governance	• Psychological Therapies • Clinical Governance Group • Workforce Governance	• Medicines Committee/ Pharmacy • Research Committee / Research Governance and Funding • Fitness to Practice • Patient Movement – Statistical Report • Infection Control • Workforce Governance • Patient Learning Report	• Rehabilitation Therapies Services • Clinical Risk Register • Patient Safety Programme • Duty of Candour • Workforce Governance • Mental Health Practice Steering Group	• Physical Health Steering Group • Patient Movement – Statistical Report • Person Centred Improvement Service • Adult & Child Protection • CPA/MAPPA • Workforce Governance
Interim Reports (as required) (15 minutes)	Covid 19	Covid 19	Covid 19	Covid 19	Covid 19	Covid 19	Covid 19	Covid 19
Special topics / items for approval (15 minutes)		Clinical Governance Stock take: • Annual Report • Terms of Reference • Reporting Structures				Clinical Governance Stock take: • Annual Report • Terms of Reference • Reporting Structures		

Longer discussion items (30 minutes)	TBA	TBA	Patient Activity	Clinical Model	Clinical Model	Clinical Care Policy	TBA	TBA

The State Hospitals Board for Scotland – Board and Sub-Committee/Advisory Committee Structure



The State Hospitals Board for Scotland – Organisational Group Structure



THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 June 2023
Agenda Reference:	Item No: 48
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

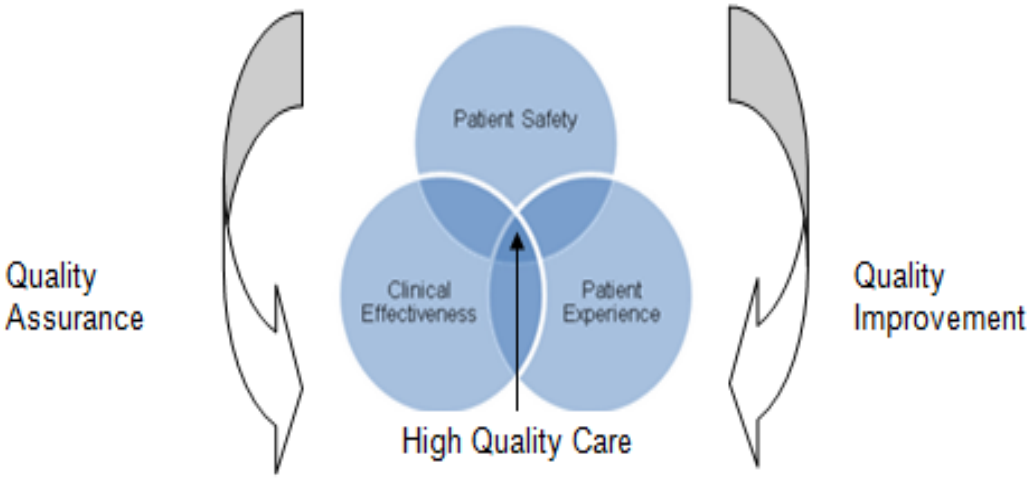
This report provides an update to The State Hospital Board on the progress made towards quality assurance and improvement activities since the last Board meeting in April 2023. The report highlights activities in relation to QA and QI and outlines how these relate to strategic planning and organisational 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 seven 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 Clinical Quality Dept staff workload/weekend working.
Route to Board (Which groups were involved in contributing to the paper and recommendations)	This paper reports directly to the Board. It is shared with the QI Forum
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 teamwork 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 JUNE 2023

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.

Due to recent patient moves to align to the new services in the clinical model, a decision was made to pause most audit work as the team that was caring for the patient at the time of the audit, will not be the same team caring for them when the recommendations are published. Once the new clinical model is officially stood up the plan of work will resume with the backlog of audits being the priority.

Variance Analysis Tool (VAT) – 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 following report compares the annual results of Treatment and Rehabilitation (T & R), Admission and Discharge pathways for the period April 22 to March 23.

Data showing improvement

Overall VAT Form Completion

Overall VAT Form completion for each of the three stages of the patient pathway was above 90% - the amount required for robust data. For the Discharge pathway, there was an improvement in completion from 84% to 91%.

Type	19/20	20/21	21/22	22/23
T & R (Annual and Intermediate reviews	95%	92%	96%	96%
Admission	92%	84%	95%	94%
Discharge	90%	73%	84%	91%

Overall CTM attendance

Overall attendance increased at Discharge CPA reviews.

Type	19/20	20/21	21/22	22/23
Discharge	55%	50%	55%	62%

For the Treatment and Rehabilitation Pathway (Annual and Intermediate Reviews) Local Delivery Plan targets are set for professional attendance. Social Work achieved their LDP attendance target

	LDP Target	20/21	21/22	22/23	% LDP target achieved/not achieved
Social Work	80%	85.6%	84.6%	80.7%	0.7%

Pharmacy

Pharmacy had staffing issues across the period, which affected all results. However, allocation of staff resources at the Admission and Discharge stage of the pathway mitigated performance in these areas.

Dietetics

Improvement in all interventions across all pathways with the exception of attendance at Admission CPA review.

Social Work

Social Work maintained good results on all interventions across all pathways.

Data showing concern from last report

During the period, staffing issues had a significant impact on Occupational Therapy, Pharmacy, Skye Activity Centre and Psychology during the period.

Although overall completion met the 90% required for robust data it should be noted that the following professions did not achieve 90% completion

Profession	T & R	Admission	Discharge
Medical	88%	88%	79%
Psychology	88%	84%	72%
Nursing		83%	86%

Overall CTM attendance

Overall attendance at the case review decreased at Annual and Intermediate CPA reviews and Admission CPA reviews. The Clinical Governance Group noted attendance levels at Admission CPA meetings and have asked that this be addressed by the new Admission and Assessment Service

Type	19/20	20/21	21/22	22/23
T & R (Annual and Intermediate reviews	73%	71%	70%	61%
Admission	66%	60%	63%	54%

For the Treatment and Rehabilitation Pathway (Annual and Intermediate Reviews) Local Delivery Plan targets are set for professional attendance. As can be seen in the table below the following professions did not achieve their LDP attendance target.

	LDP Target	20/21	21/22	22/23	% LDP target achieved/not achieved
RMO	90%	80.7%	87.2%	83.8%	-6.2%
Medical - overall	100%	81.3%	90.3%	91.0%	-9.0%
KW/AW	80%	67.5%	58.5%	57.6%	-0.9%
Nursing - overall	100%	95.2%	97.0%	96.3%	-0.7%
OT	80%	76.5%	77.4%	41.4%	-38.6%
Pharmacy	60%	65.1%	81.5%	58.1%	-1.9%
Clinical Psychologist	80%	66.9%	68.7%	59.2%	-20.8%

Psychology-overall	100%	78.4%	84.7%	80.0%	-20.0%
Security	60%	45.8%	41.0%	43.0%	-17.0%

Key Worker/Associate Worker (KW/AW) attendance across all three pathways. This is an ongoing challenge for the organisation due to staffing resource issues.

KW/AW attendance	T & R	Admission	Discharge
20/21	68%	53%	50%
21/22	59%	46%	50%
22/23	58%	42%	45%

Psychology
Reductions in interventions across all pathways – Clinical Quality to meet with department head to investigate solutions.

Any challenges with the systems that are being addressed

A project is currently underway to investigate using RiO to collect performance data going forward. This is part of the overall CPA review project looking at using RiO to populate the CPA document and to ensure that patient information is stored in one central point (RiO). This would resolve the data completion issues.
The issues highlighted by the VAT are vacancies in some departments and keyworker attendance at CPAs.

Please highlight any support required

Support from all professions and clinical secretaries to ensure that all patient information and reports are stored in RiO in a way that data can be pulled from the system

Clinical Quality Flash Reports to Activity Oversight Group

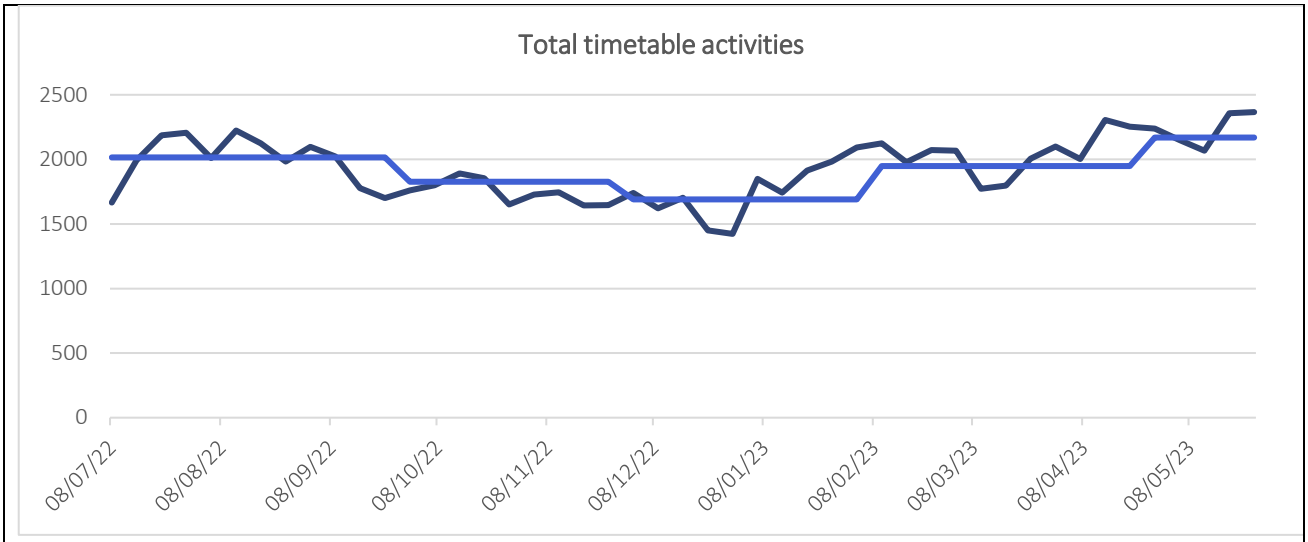
The Activity Oversight Group took over the role of monitoring the activity data earlier this year. Clinical Quality now produce a flash report for each meeting that highlights areas of improvement, concern and any system issues. The most recent report is below and will be discussed in full at the Activity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

CLINICAL QUALITY FLASH REPORT

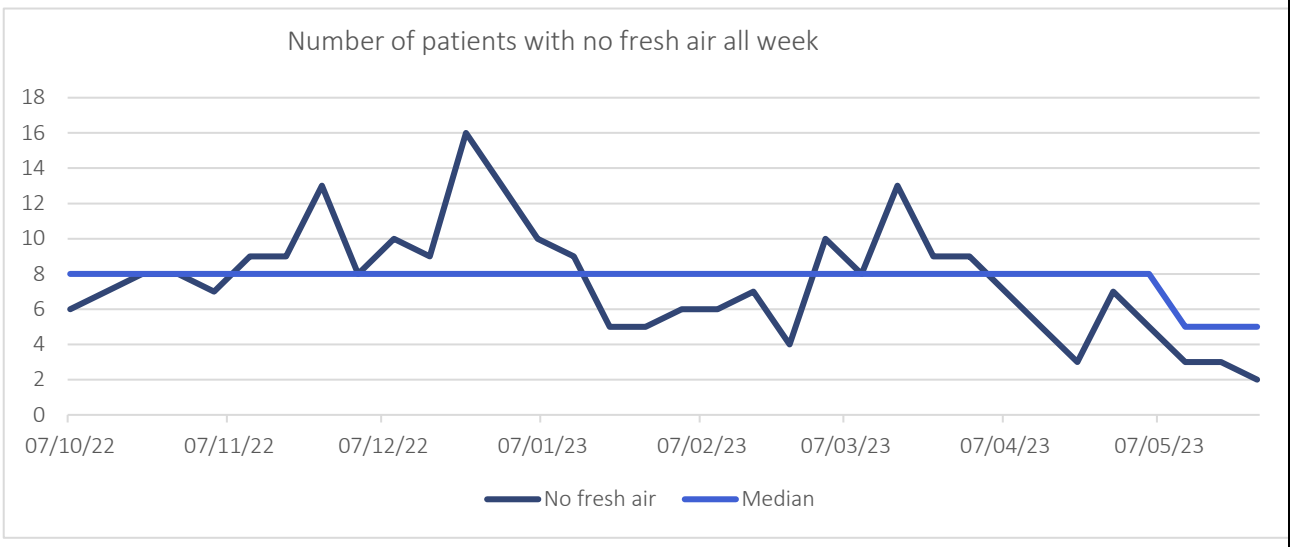
Date: June 2023

Data showing improvement from this time last year

There has been a steady increase to the number of timetable sessions provided compared to this time last year. Timetable sessions are a variety of activities that patients take part in each week. They cover physical activity, psychotherapeutic, activities of daily living, social, educational and spiritual/cultural.

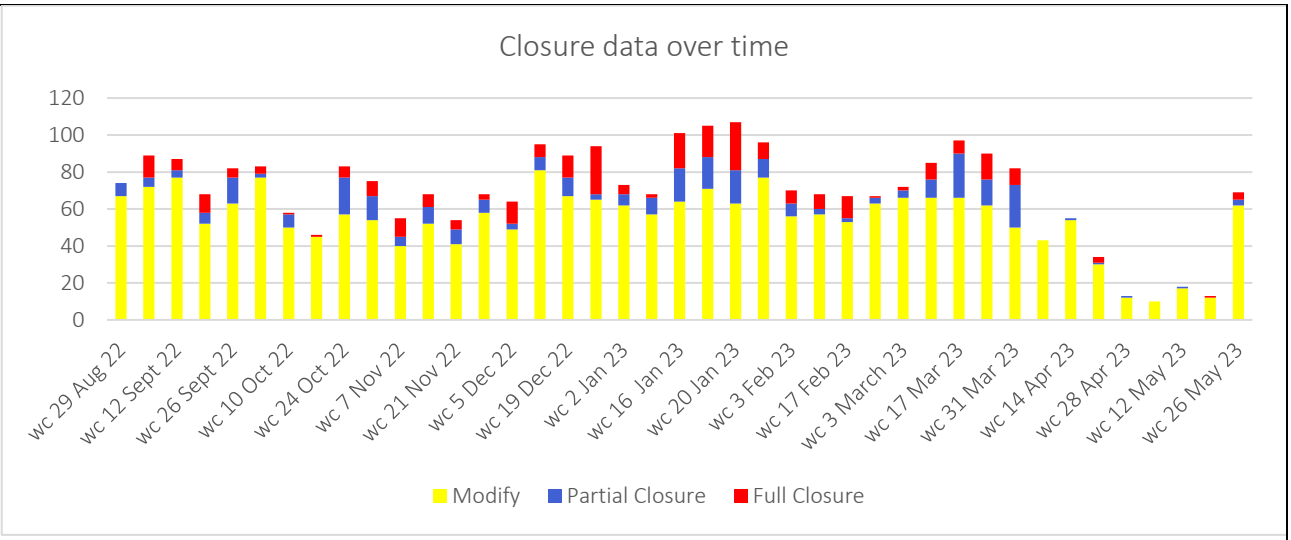


Please note that the way the data was collated changed in October 2022 so there is no data from this time last year for comparison.
We can however see a decrease in the number of patients with no fresh air all week. In particular, this has been a steady decline over the last 4 weeks, which may be linked to improvements in the weather.



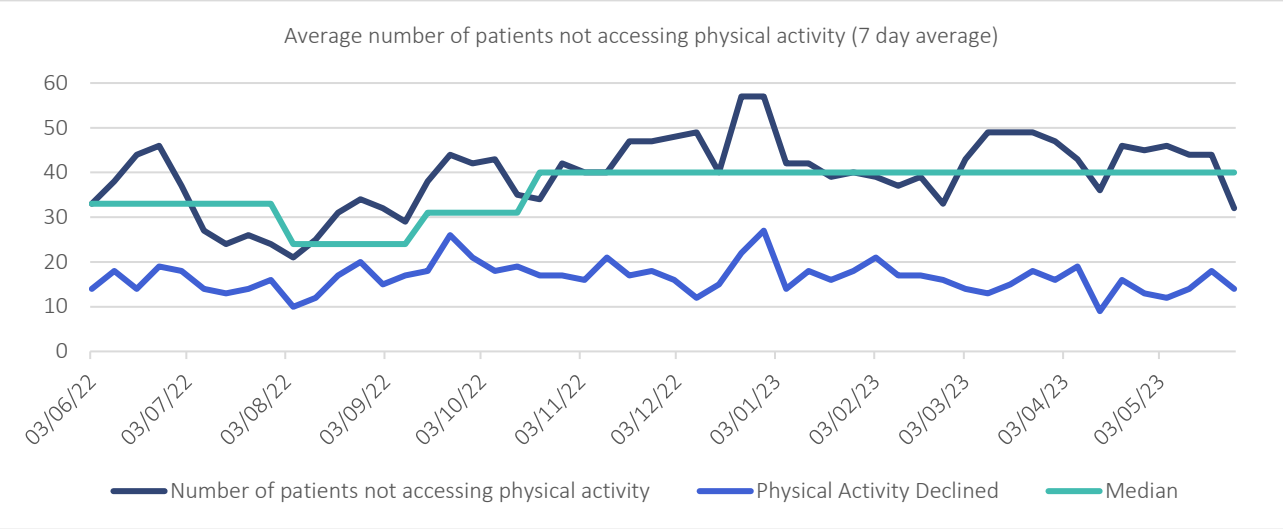
Data showing concern from last report

This data was collected in this way from the 29th of August 2022. Although we are unable to compare with figures from this time last year, we see an increase again in closures in recent weeks.

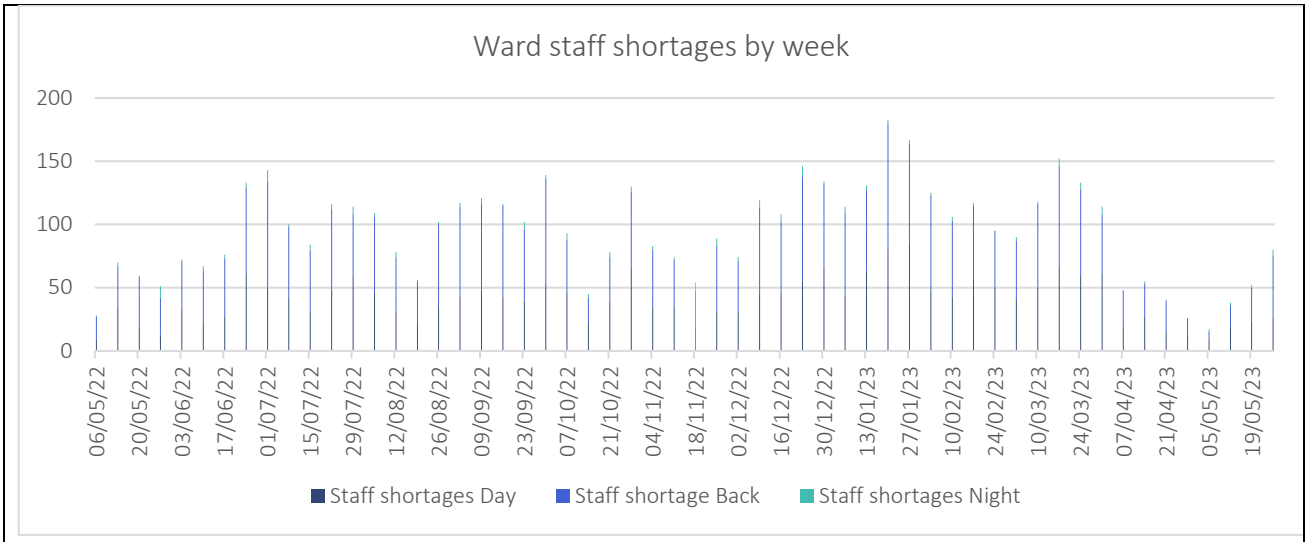


Areas with sustained levels

The graph below shows similar levels of patients not accessing physical activity.



The graph below shows similar ward staff shortage levels as previous year.



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

Live Testing for the project to archive the use of Physical Activity forms and see all activity data coming from the timetable is now complete. An issue has arisen following the update to RiO and should be rectified in the coming days. Once this has taken place, a communication will be sent to all nursing staff to advise that Physical Activity need only be recorded in the timetables going forward.
A Day Time Confinement Oversight Group has been established to address issues around modified ward working / closures.

Any challenges with the systems that are being addressed

Update to RiO has affected the above ongoing Physical Activity work.

Please highlight any support required

Support required from I.T colleagues.

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 and build capacity to support and embed QI. A QI projects database has been developed and updated to reflect the range of projects being taken forward across TSH.

QI Capacity Building

QI Essential Training is being delivered over 2 days in June to TSH staff,. Further planning is underway to deliver this again later in the summer. ScIL training is ongoing with 3 TSH staff on current cohort. Project planning is underway for each participant. TSH have been successful with one application for the Scottish Coaching and Leading for Improvement Programme (SCLIP). This will commence later in the summer.

Early planning is underway to offer another round of TSH3030. The aim of this would be to support new teams in QI activity following the implementation of the Clinical Model.

QI Case Study – Development of the Nutritional & Physical Health Care Checklist

The following Case Study details a QI project to review the existing Health and Wellbeing Plan and replace with a Nutritional & Physical Health Care Checklist. The paper details the QI methodology used and highlights the input from both staff and patients. The QI Project Team continue to meet fortnightly and the next phase of testing will commence in Arran Hub, with more qualitative data being requested from staff, through feedback forms and will continuing to use the PDSA cycle to learn from.

QI Project to review the Health and Wellbeing Plan with an intention to modify the plan to be more user friendly and provide a more detailed tool to identify concerns in relation to patient's nutrition and physical health needs:

Initially Health & Wellbeing plans were introduced to encompass a multidisciplinary approach to holistic physical health care. Anecdotal feedback received indicated that improvements could be made to identify who has responsibility for completion. It was agreed through supporting healthy choices to review the current Health and Wellbeing Plans and the outcome was to replace these with a more comprehensive nutritional and physical health checklist. The project began in January 2022

The new checklist initially started with four section; Physical Health Care, Nutritional Health, patients' weights and physical activity and focus on a more patient friendly approach. These replace the individual eight plans identified through the previous Health and Wellbeing Plans.

Although this project has had some delays, due to a number of reasons mainly due to staff role changes. From January 2023, the project has moved forward considerably where by flash reports (Table 1) are being used as a Plan, Do, Study, Act (PDSA) format to keep the group focused and to learn from, going forward.

Nutritional & Physical Health Care Checklist Flash (PDSA) Report – May 2023

Successful implementation is a shared responsibility.

Aim of Report:

To provide an update on the develop of a comprehensive Nutritional and Physical Health Care checklist to replace 8 Health and Wellbeing plans which will completed by Keyworker and discussed monthly with Patients from admission to discharge.

Overview of the Nutritional & Physical Health Care Checklist:

New Nutritional & Physical Health Care Checklist have been developed to replace 8 Health and Wellbeing plan, which will provided more detailed overview on all patients physical health needs and reduce the amount of time to complete these

Key Project Milestones:

To deliver Nutritional and Physical Health Care Checklists , the following Key Planning Elements require to be developed:

- Standard Operating Procedure
- Timeline
- Process Mapping
- Training
- Monitoring

Activity in April / May 2023:

- Agreement for further testing on Arran Hub
- Feedback form completed for staff feedback
- Guidance Document updated
- Process mapping completed from admission – discharge
- Project Team member updated PPG Meeting on the importance of the Checklist
- Clinical Quality Improvement identified as team to monitor completed checklists
- Feedback provided to the OBG

Planned Work in May 2023:

- Train clinical staff within Arran Hub. Trainers have been identified
- Where does the group go next

What worked well

- Dedicated meetings times for the project team
- Development of timeline to identify clear goals for completion
- Feedback from staff was essential

Work better if !

- Allocating time for training

Communication and Engagement:

Updates are communicated through:
Physical Health Steering Group
Supporting Health Choices
QI Forum
E-health / OBG

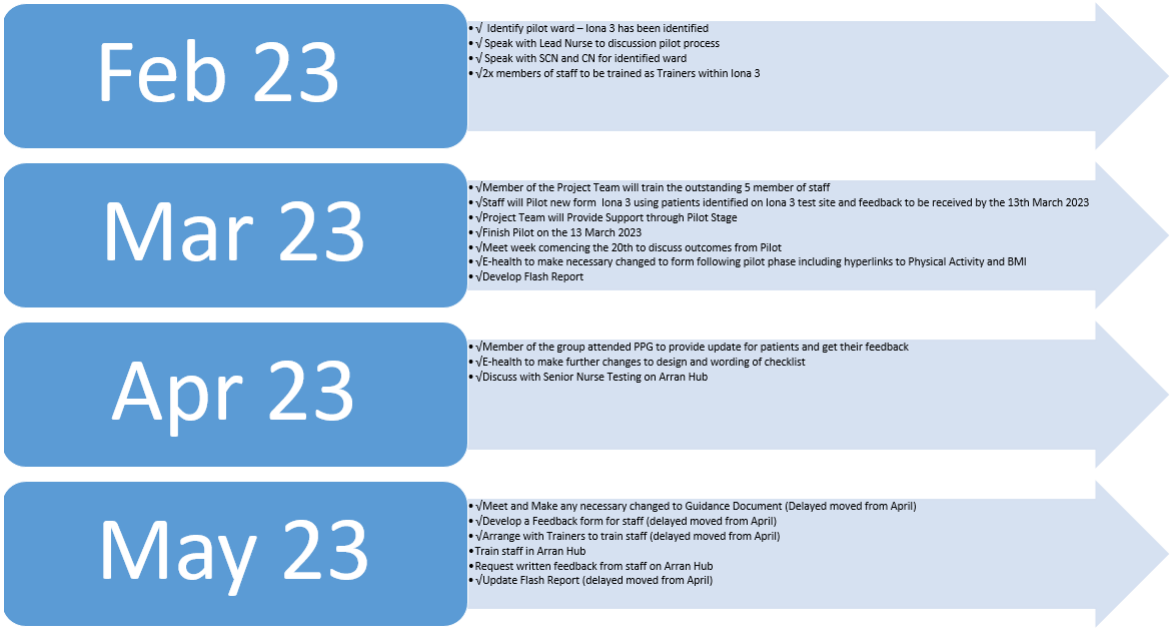
Planned Meetings – May 2023

Project Team meeting 24/05/2023

Contact Details:

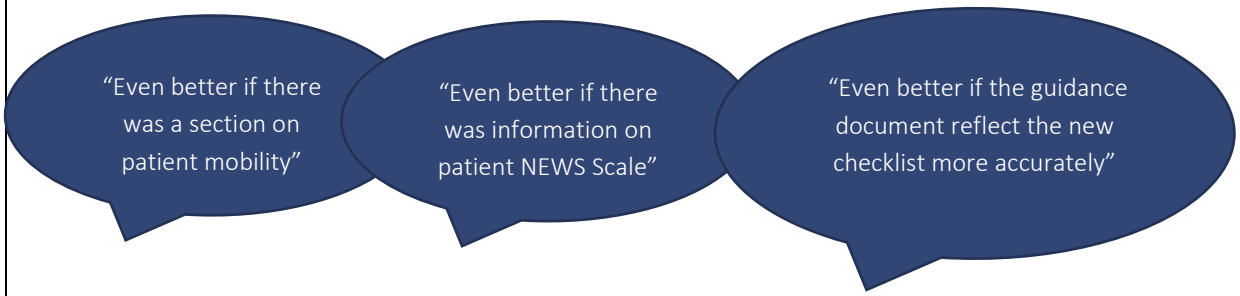
- If you have any queries or concerns, please contact Frances Waddell, Karen Burnett, Hannah MacAlistair, Andrew Service or Tracy Tait

Timeline introduced to keep the group on top of actions. There was a slowdown in April 2023 due to holidays, which has delayed the work due to be completed through May 2023.



First point of testing was on Iona 3 through March 2023 on the RiO test site as part of population segmentation and qualitative feedback by asking staff "what worked well", the feedback received was positive:

Staff were also asked what could be done to make the checklist "even better" and the feedback received from clinical staff were

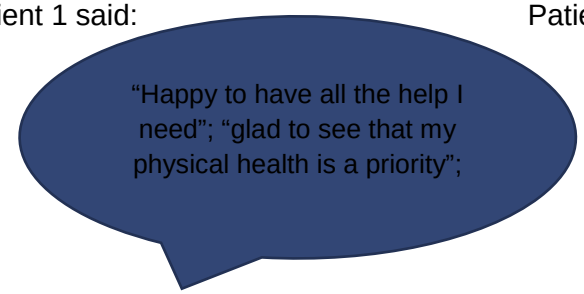


Following this feedback, a process mapping exercise was completed and the guidance document updated to ensure that clinical staff have the necessary information available to complete the checklist accurately. Two new sections were added to include a section on patient's mobility and information on patients' NEWS score.

Members of the project team attended the Patients Partnership Group to provide information to patients on why the nutrition and physical health care checklist is important and patient's feedback was positive. The patients valued the importance of their health and acknowledge that some of the

questions may be repetitive each month. Once explanation was provided on the capabilities of RiO they were accepting of this.

Patient 1 said:



Patient 2 said:

The QI Project Team continue to meet fortnightly and the next phase of testing will commence in Arran Hub, with more qualitative data being requested from staff, through feedback forms and will continuing to use the PDSA cycle to learn from.

Realistic Medicine

Realistic Medicine (RM) is the Chief Medical Officer (CMO) 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. In December 2022, Scottish Government published "Delivering Value Based Health and Care" (VBH+C), setting out the vision for VBH+C and reinforcing the RM approach as the vehicle through which VBH+C would be realised.

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

The updated Realistic Medicine action plan was submitted to Scottish Government in May. This is attached as appendix 1 The 23/24 Action Plan is more focussed and streamlined than the previous year's plan. It has detailed tangible aims/outcomes for projects. The introduction incorporates the Value Based Health and Care (VBH&C) vision and commitments. We have also structured the action plan around the 6 VBH&C commitments, as well as aligning each of the projects with one or more of the RM principles.

TSH has had an RM Clinical Lead and, since 2021, an RM Project Manager (post currently vacant). Funding for these two posts has recently been extended for 23/24. The recruitment process for a new Project Manager is progressing.

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 and reviewed for relevancy by the Clinical Quality Facilitator. During the period 1 April 2023 to 31 May 2023, 35 guidance documents have been reviewed. There were 23 documents which were considered to be either not relevant to TSH or were overridden by Scottish guidance and 5 documents which were recorded for information and awareness purposes. Of the remaining 2 guidelines, 1 is pending a decision regarding relevancy to TSH whilst the other regarding Acne is currently undergoing the evaluation matrix process.

Table 2: Evidence of Reviews

Body	Total No of documents reviewed	Documents for information	Evaluation Matrix required
Mental Welfare Commission (MWC)	2	2	0
Healthcare Improvement Scotland (HIS)	3	3	0
National Institute for Health & Care Excellence (NICE)	30	0	2

As at the date of this report, there are currently an additional 3 evaluation matrices nearing the end of the review process.

Table 3: Evaluation Matrix Current Situation

Body	Title	Allocated Steering Group	Current Situation	Publication Date	Projected Completion Date
SIGN	National Clinical Guideline for Stroke	PHSG	CQ and Practice Nurse to review content and decide on how to take this guideline forward as it contains over 530 recommendations which will not all be relevant to TSH	April 2023	July 2023
NICE	Acne Vulgaris UPDATED	PHSG	Guideline updated since early 2023 with 4 new recommendations. Evaluation matrix currently with Practice Nurse for completion	May 2023	June 2023
NICE	Head Injury: Assessment and early management	PHSG	Given that SIGN 110 and SIGN 130 are now out of date with no future plans to review, NICE guideline to be reviewed for need for evaluation matrix to be completed.	May 2023	August 2023

There are currently 5 additional evaluation matrices, which have been outstanding for a prolonged period and await review by their allocated Steering Group. The progress of the first two 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 summer 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. This was flagged up for review as a matter of urgency upon the appointment of the Supporting Healthy Choices Project Officer. The gap analysis has been updated and still requires to be reviewed by the group however the Project Officer role is currently vacant and further guidance is awaited.

The Rehabilitation after Traumatic Injury guidance from NICE is currently approaching the end of the review process – it should be noted that this is a fairly comprehensive document and as such, an amended review process is being followed in order to reduce the time required by all MDT members involved.

The final guidance review regarding MS has temporarily been placed on hold pending diagnostic investigations being conducted on 1 patient. The GP and Practice Nurse are aware of the content of the guideline however feel it would be more prudent to work through the content in tandem with the investigation process given that there has been no previous history of any patient with this diagnosis.

Table 4: Evaluation Matrix Summary

Body	Title	Allocated Steering Group	Current Situation	Publication Date	Projected Completion Date
HIS	From Observation to Intervention: A proactive, responsive & personalised care & treatment framework for acutely unwell people in mental health care	Patient Safety	Evaluation matrix completed with 28 outstanding recommendations Patient Safety meeting took place mid-September. Evaluation matrix being updated as draft Clinical Care Policy is now currently under consultation phase.	Jan 2019	Summer 2023
MWC	The use of seclusion	Patient Safety	Work ongoing. Release of updated Seclusion Policy currently on hold due to ongoing work with Clinical Care Policy currently under consultation with seclusion tier 1 and 2 being incorporated. Both to be launched together.	Oct 2019	Summer 2023
PH England	Managing a healthy weight in adult secure services - Practice guidance	Supporting Health Choices (SHC)	Unable to be completed within the tight deadline set by SHC group due to poor attendance at review meeting & delay in members submitting feedback (May 2021) prior to group being paused. Documents provided to newly appointed SHC Project Officer in order to progress this and obtain an outcome (Jan 2023). Matrix updated (Mar 2023) though still requires review & agreement of content by SHC group. SHC Project Officer no longer in post.	Feb 2021	Apr 2023
NICE	Rehabilitation from Traumatic Injury	PHSG	After being considered not relevant to TSH setting, decision was changed & evaluation matrix was required (Apr 2022). Due to large number of recommendations, review process was split into 2	Jan 2022	Mar 2023

Body	Title	Allocated Steering Group	Current Situation	Publication Date	Projected Completion Date
			parts: Part 1 - reviewed by AHP/Manual Handling Advisor (commenced June 2022 & completed Dec 2022) & Part 2 - wider multi-disciplinary review. Part 2 review commenced Jan 2023 with deadline of 3rd Feb 2023. Psychology feedback received and review matrix undergoing final review with aim to discuss and sign off at next PHSG in June 2023.		
NICE	Multiple sclerosis in adults: Management UPDATED	PHSG	Previously reviewed in Oct 2014 when recorded for information purposes only. Given that TSH had no patients with an MS diagnosis PHSG agreed that should this change, the guideline would be used. Current 2022 situation was same however there is now 1 possible diagnosis pending with patient on waiting list for further investigation. Completion of matrix placed on hold until outcome	June 2022	2023 Awaiting outcome from specialist referral (March 2023)

Appendix 1

Realistic Medicine Action Plan

THE STATE HOSPITAL

REALISTIC MEDICINE ACTION PLAN, 2023-24

"'By 2025, we will support the Health and Social Care workforce to practise Realistic Medicine, thereby enabling the delivery of high quality and personalised care to the people of Scotland.'"

Chief Medical Officer, 2022

Introduction

Realistic Medicine (RM) is the Scottish Government's approach to delivering Value Based Health and Care (VBH&C) in Scotland. VBH&C is defined as "*the delivery of better outcomes and experiences for the people we care for through the equitable, sustainable, appropriate and transparent use of available resources*". VBH&C is based on the primary principle of person-centred care - care that is not only high in quality but also delivers the outcomes and experiences that really matter to people, defined by and reported by them. In addition, VBH&C seeks to reduce the waste, harm and unwarranted variation that exist across our health and care system. The equitable distribution of resources is key to delivering VBH&C. It is by practising RM that we will deliver VBH&C.

In December 2022, the Scottish Government published a vision for VBH&C in Scotland:

"By 2030 all health and care professionals will be supported to deliver Value Based Health & Care. This will achieve the outcomes that matter to people and a more sustainable system."

Scottish Government have made six commitments to help deliver the VBH&C vision for Scotland. These are to:

1. Continue to promote RM as the way to deliver VBH&C.
2. Promote the measurement of outcomes that matter to the people we care for and explore how we can ensure a coordinated approach to their development and implementation.
3. Continue to support the development of tools that enable health and care colleagues to seek out and eliminate unwarranted variation in access to healthcare, treatment, and outcomes.
4. Continue to build a community of practice and a culture of stewardship across Scotland.

5. support delivery of sustainable care in line with the NHS Scotland climate emergency and sustainability strategy by reducing waste and harm; and,
6. Continue to engage with the public to promote understanding of RM and VBH&C and its benefits for Scotland. We will also work to empower people to be equal partners in their care, through shared decision making enabling self-management, and promoting health literacy and healthy lifestyle choices.

So, what is Realistic Medicine?

RM puts the person receiving health and social care at the centre of decisions made about their care. It encourages health and care workers to find out what matters most to patients so that their care fits their individual preferences, needs and situation. RM recognises that "a one size fits all" approach to health and social care is not the most effective path for the patient or the NHS. The original six principles of RM set out in 2016 are still in place today. These are:

Evidence shows that if people are fully informed about the risks and benefits of their treatment options they choose less treatment, or more conservative treatment. That is why shared decision making sits at the heart of RM. It supports people, and their families, to feel empowered to discuss and consider their treatment options and the associated risks and benefits. This approach can help manage expectations and enables people to make informed choices, based on what matters most to them. In some cases, this may mean they choose different treatments, which offer greater personal value. In other cases, they may choose less or no treatment, which will help reduce wasted resources.

Understanding people's preferences does not mean that we always give people what they want, because we know that there are times when it may not be appropriate or practical for us to do so. But we should always consider what matters to them and try to better understand how their health and wellbeing fits into the broader context of their lives. In the context of forensic mental health services, this can be particularly challenging. We care for patients subject to legal compulsion to be in hospital and receive treatment, often against their wishes. This means that, understanding and delivering true shared decision making and personalised approaches to care, may require some different approaches and may look different from other parts of the health and care system. While it is important to note these differences, The State Hospital (TSH) is clear that these differences should not be considered insurmountable barriers to as full an implementation of the principles of RM as is possible.

TSH's RM Action Plan

The State Hospitals Board for Scotland is a special health board. It provides care for 120 men from Scotland and Northern Ireland in a high secure setting who have a major mental disorder and a serious history of violence. The TSH RM action plan for 2023-24 demonstrates the commitment of the organisation to delivering VBH&C via the RM principles and provides the mechanism through which progress towards this aim is measured and monitored. This year's action plan has a renewed focus on specific projects relevant to the RM principles. Projects that have been completed or are not directly relevant to the RM action plan over the next 12 months, have been removed or included in relevant appendices for completeness. The communications plan has been incorporated into the main action plan, rather than sitting separately. Each project has also been aligned with the relevant VBH&C commitment from the Scottish Government's VBH&C action plan. It is hoped this provides a more accessible and meaningful plan for the staff of TSH and the wider group of stakeholders who will access it.

Delivery and governance of RM in TSH

The RM Team in TSH currently consists of the RM Clinical Lead (1 day per week, 2PAs) and the RM Project Manager (1 day per week Band 6). The RM Team is responsible for the development and renewal of the RM Action Plan and some specific areas of work within the plan. The RM Team also communicates regularly with Scottish Government and the other RM Clinical Leads and Project Managers across other Board areas. The RM Team reports 6 monthly to the Clinical Governance Group in TSH and annually to the Clinical Governance Committee within TSH and the RM Team at Scottish Government

TSH Action Plan 2023-24

Commitment 1 - Continue to Promote Realistic Medicine							
Department/Course	**Project Title**	**Location**	**Lead**	**Start date**	**End Date**	**Project progress and update**	**Realistic Medicine Link**
Communications	Engagement and Awareness of Realistic Medicine within VBH&C	All	Dr. Gordon Skilling	Jul-05	Ongoing	Staff bulletins twice annually. Seminar Series twice annually Presentations at staff development. Flash Report post on the intranet. Evidence based Realistic Medicine summary. Realistic Medicine Intranet Page.	-Shared Decision Making -Personalised Approach to Care -Reduce Harm and Waste -Reduced Unwarranted Variation -Manage Risk Better -Become Improvers and Innovators

Commitment 2 - Promote the Measurements of Outcomes							
Department/Course	**Project Title**	**Location**	**Lead**	**Start date**	**End Date**	**Project progress and update**	**Realistic Medicine Link**
Research and Development	Clinical Outcomes Monitoring Process: More effective engagement of frontline clinical staff in utilising the wide range of available data to inform and support clinical decision-making.	All	R & D Manager	2020	Ongoing	Clinical Quality staff have been aligned with clinical teams to support the use of data to inform clinical decision making and improvement. Clinical Operational Guidance has been drafted for each of the services in the new clinical model. The guidance includes a range of measures to be used in each services to monitor and improve the quality of care. Feedback from the Patient Partnership Group on what measures matter to the patients has been incorporated. For some time there has been discussion at TSH about considering a more global functional outcome measure to determine the progress, or otherwise, of patients. The MHPSG have been piloting two outcome measures, one in Arran Hub – The FORUM - and one in Mull Hub – the Clinical Global Impression Scale. The former is a longer questionnaire but encompasses both self-report by patients and team-report – this has demonstrated preliminary benefits in being able to pick up change and discrepancies between team and self-views on progress. The CGI is a brief snapshot type instrument using only team-report. A quantitative and qualitative analysis of six months of use of the measures will be completed in Summer 2023 after there is a chance to speak to teams about their experiences using the measures.	-Personalised Approach to Care -Reduce Harm and Waste -Reduce Unwarranted Variation

Commitment 3 - Continue to Support the Development of Tools							
Department/Course	**Project Title**	**Location**	**Lead**	**Start date**	**End Date**	**Project progress and update**	**Realistic Medicine Link**
Supporting Healthy Choices	To review the process for completing Nutritional and Physical Health Care checklists in line with National Food, Fluid & Nutrition Standards.	All	Frances Waddell Karen Burnett Hannah McAllister Andrew Service Tracy Tait	Jul-21	Ongoing	Feb 2022: Health and Wellbeing Plan have been replaced with new Nutrition, Physical Wellbeing Plans. This has moved from a very lengthy process for clinical staff to a shorter checklist version. Currently being tested in Iona 3 with Clinical Staff over a 3 week period. March 2023: testing completed within staff group and using the "could be better if" approach with feedback received from testers. Checklist being amended and further testing with patient group. April 2023: further testing is being completed at this time.	-Reduce Harm and Waste -Reduced Unwarranted Variation
SciL	There will be a cohesive, multidisciplinary decision-making process around the provision of activity within 14 days for patients admitted to TSH.	Arran 1 Lewis 1 Iona Hub	Julie McGee	Jan-23	June-23	Meeting with members of project team to design Activity Plan Template. Action to have Arran 1 and Lewis 1 brainstorming session to gain buy in of RMO's in Admission service. Project being well received. Constraints of time in diaries atm. May 2023: This will be brought to the Admission Service HLT when in place.	-Shared Decision Making -Personalised Approach to Care -Reduce Harm and Waste -Reduced Unwarranted Variation -Become Improvers and Innovators
Mental Health Practice Steering Group	CPA Process Review	All	MHPSG	2022	Ongoing	The aim of the review is to support a more co-productive approach to all aspects of CPA care planning. The project will need to consider the changes that may be brought about by the planned revision of the hospital Clinical Model, and the opportunity for the level of patient involvement and shared decision making to be dependent on the stage at which the patient is in their journey through high secure forensic care. March 2023: First draft shown to MHPSG awaiting input from Psychology regarding Risk and Formulation. View of second draft being presented in May MHPSG. The document will then be circulated to stakeholders for consultation.	-Personalised Approach to Care -Reduce Unwarranted Variation -Manage Risk Better

Mental Health Practice Steering Group	Pre-admission Specific Needs Form: Ongoing Development	All	MHPSG	Apr-22	Ongoing	The ongoing development of the Pre-admission specific needs form and associated process is aimed at ensuring a person-centred approach to care, and anticipating any communication difficulties which may impact on the shared decision-making aspect of care prior to a patient being admitted to the hospital. The process should ensure clinical teams have an early understanding of the specific needs of all newly admitted patients to support the early implementation of a personalised approach to care. May 2023: This is monitored quarterly by the MHPSG. The process has been changed so that the referring unit completes the document - there continues to be random variation around completion of the document and this will be brought up at the Admission and Assessment Hub Leadership Team once the new service is up and running.	-Personalised Approach to Care -Reduce Unwarranted Variation

Commitment 4 - Continue to Build a Community of Practice							
Department/Course	**Project Title**	**Location**	**Lead**	**Start date**	**End Date**	**Project progress and update**	**Realistic Medicine Link**
Records Management	Introduction of Business Classification Scheme (BCS)	Health Records Pilot Group	Karen Mowbray Tracy Tait	Nov-22	Ongoing	February 2023: Team have met to discuss project aim. Now going to be more focussed on 'housekeeping' on record department with the BCS as an add on to this. Group meeting to be arranged in April. April 2023: Time has been arranged for Karen and Tracy to meet on a fortnightly basis to review and start to examine the project and who will be required to be involved. May 2023: Change in focus of project to cleanse and reorganise current data.	-Reduce Harm and Waste -Manage Risk Better -Become Improvers and Innovators
TSH3030 TSH365	Monitor the number of QI initiatives in place under a TSH365 model when compared to success of TSH3030.	Quality Improvement	QI Forum	2021	Ongoing	QI Forum continued to meet and QI projects within hospital are supported. May 2023 - QI projects database now live and projects updated monthly.	-Become Improvers and Innovators

The Forensic Network	Citizens Jury Recommendations Event: to review the Jury's recommendations and to develop an action plan to address the issue of SDM within the FN	Event	RM LeadRM Programme Manager	2021	Ongoing	So far, it has not been possible to progress a joint piece of work across the Forensic Network on SDM. In TSH, we continue to promote the online SDM module (no. of staff completed as of March 23 – 63. We are looking at a model of local SDM "champions" on each Hub to promote the module. A piece of work around use of the BRAN questions is a key aim for the coming year 23/24.	-Shared Decision Making -Personalised Approach to Care -Reduce Harm and Waste -Become Improvers and Innovators
Quality Improvement	QI Training	All	QI Forum	2022	Dec-23	QI training provided by NES - TSH has 3 staff on 2023 ScIL cohort and 1 staff on SCLIP. Internal QI Essential training in development with plan to deliver to a staff team in June and August/September 2023.	-Become Improvers and Innovators
Learning into Practice	LiP Meetings and System: providing multidisciplinary staff with a process to identify, share, reflect and discuss experiences and generate learning and change ideas from their practice.	All	Project Lead	2022	Ongoing	Guidance and governance structures for LiP system agreed. 3 LiP meetings completed so far. Lots of learning on how we can improve the process for clinical teams – especially on how we can encourage participation. This remains a key aim for TSH moving forward.	-Reduce Harm and Waste -Manage Risk Better -Become Improvers and Innovators
The Forensic Network	Continuous Quality Improvement Framework Reviews (CQIF)22	All	Forensic Network Manager	2022	2025	The CQIF Reviews provide the opportunity for consistent benchmarking and auditing across the forensic mental health estate. Production of standards within the review process which incorporate the principles of realistic medicine where appropriate. March 2023: The third round of the Continuous Quality Improvement Framework Reviews has commenced with a standard setting workshop.	-Reduced Unwarranted Variation

Commitment 5 - Support Delivery of Sustainable Care							
Department/Course	**Project Title**	**Location**	**Lead**	**Start date**	**End Date**	**Project progress and update**	**Realistic Medicine Link**
ScIL	Reducing the Spread of Infection	All	Tracy Tait	Jan-23	Dec-23	March 2023: Part of ScIL Course, Project team identified and first meeting due on the 11th April 2023. The initial meeting will be to "set the scene". Keen to have patient involved will also be included within this project possible use of empathy mapping tool. April 2023: First meeting took place on the 11th April with Project Team, where information was provided on the project and the aim. Next meeting scheduled for the 27.04.2023 to look at empathy mapping exercise.	-Reduce Harm and Waste -Reduce Unwarranted Variation -Become Improvers and Innovators
08:30 Huddle	To implement a template that can be used at the 08:30 huddle to ensure we have the information to make decisions regarding ward closures	All	Suzanne Boyce Tracy Tait	Dec-22	Dec-23	Carrying out daily PDSAs to enhance the template and ensure we have all the data we need to make decisions around ward closures. April 2023: Newly appointed resources administrator can develop forms on excel which will automatically collect the data, therefore streamlining further.	-Reduce Harm and Waste -Reduce Unwarranted Variation -Manage Risk Better
Product Request Form	To review process for ordering products for patients use and implementing a template to inform decision making around ordering equipment	All	Suzanne Boyce Tracy Tait	Dec-22	Dec-23	March 2023: Meetings with project team. Review of current system used. Discussions under way to improve the process of stock ordering using an empathy mapping and process mapping style. April 2023: New process has been developed and tested with several orders where changes had to be made to the process to make it streamline better. Feedback meeting has been arranged for the 20.04.2023.	-Reduce Harm and Waste -Reduced Unwarranted Variation

Practice Development	Clinical Supervision	All	Hannah McAllister	Dec-22	Ongoing	May 2023: There is currently training days for staff across the site. The project is at the planning stage for the first test of change when we have enough people trained. This is also communicated with NES regarding this pilot as it is a National Strategy for Nursing and sits with other national drivers for change.	-Reduce Harm and Waste -Manage Risk Better
Practice Development	Patient and Staff Debriefs: to ensure that following certain incidents within the hospital that the staff and patients have a meaningful debrief.	Iona Hub	Hannah McAllister	Aug-22	Ongoing	Number of debriefs that take place following incidents – patient and staff. Feedback from patients as to the benefit of a patient debrief. Currently undergoing a scoping exercise with other services to allow benchmarking. March 2023: Currently piloting in Iona Hub.	-Reduce Harm and Waste -Manage Risk Better
Business Support	Development of a New Observation Policy	All	Nursing Practice Development IOP Lead	Apr-21	Nov-22	The Improving Observation Practice (IOP) work was initially focused on the identification of practice, provision of a consistent approach, investigating what could be considered a restrictive practice for patients, and looking into the staffing requirements with specific focus on level 3 observations. That initial work resulted in the development of a new Observation policy. May 2023: The observation policy “Clinical Care Policy” is being amended then it shall go to policy approval group meeting. This policy is an also an agenda item for the Patient Safety meeting and NAPAC meeting.	-Manage Risk Better -Personalised Approach to Care -Reduced Unwarranted Variation

Commitment 6 - Engage with the Public to Promote Understanding							
Department/Course	**Project Title**	**Location**	**Lead**	**Start date**	**End Date**	**Project progress and update**	**Realistic Medicine Link**
Patient Advocacy Service	Patient Advocacy Service (PAS) Initiatives	All	PAS Manager	2022	Jan-24	Had an initial discussion on better access whilst in seclusion and will be taking a paper to the Person-Centred Improvement Steering Group following verbal approval from the PCI Lead, hopefully by August 2023 which would then need approved by various other groups. January 2024 would be a realistic timeframe for implementation and any data protection approvals which may be required.PAS input for patients in general hospitals - An initial proposal was submitted to the PCISG which was agreed in principle, a full paper has been requested which will be submitted for the June meeting. Following approval, it would go through the various stages and would ensure a protocol was in place for patients transferred to general hospitals to have continuous input from PAS. Anticipate December 2023 as a realistic timeframe. The ward drop in remains a priority following the clinical model implementation. Monthly drop in as per our SLA. Awaiting the final moves and a settling period before we explore the best days/times for staff to visit. Anticipate this being completed by September 2023.	-Shared Decision Making -Personalised Approach to Care
Mental Health Practice Steering Group	Advance Statements	All	MHPSG PAS Manager	Jun-22	Ongoing	The main outcome of the review will be that all Advance Statements in place will have been developed in a co-productive way to ensure they are actionable within the context of high secure care but provide clear advance information on a patient's wishes should their illness affect their capacity to consent to treatment. Aim is to Advance Statement alongside the patient's dispensing documentation. Monitoring of the proportion of patients who do not have an advance statement will continue with feedback sought from those patients who have made the decision that they do not want an advance statement. Continues to feedback to MHPSG.	-Shared Decision Making -Personalised Approach to Care

Realistic Medicine	Shared Decision Making Online Module	All	Learning and Development Department	2022	Apr-24	Shared Decision Making online module to be added to the TSH Learnpro platform as a module available for all staff. Number of staff who have completed the SDM module. Plan to contact Charge Nurses from each ward to identify 'link nurse' who could complete the training and be knowledgeable on the topic for the ward. The target is to have 50% of clinical staff having completed the module by April 2024.	-Shared Decision Making -Manage Risk Better -Become Improvers and Innovators

THE STATE HOSPITALS BOARD FOR SCOTLAND

Clinical Governance Committee

Minutes of the meeting of the Clinical Governance Committee held on Thursday 9 February 2023.

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

Chair:	
Non-Executive Director	Cathy Fallon
Present:	
Vice Board Chair	David McConnell
In attendance:	
Person Centred Improvement Lead	Sandie Dickson [Item 8]
Head of Psychology	Liz Flynn [Item 6]
Consultant Forensic Psychiatrist	Dr Sheila Howitt [Item 14]
Chief Executive	Gary Jenkins
Director of Nursing and Operations	Karen McCaffrey
Director of eHealth and Finance	Robin McNaught
Head of Planning and Performance	Monica Merson
Board Chair	Brian Moore
Head of Corporate Governance & Board Secretary	Margaret Smith
Head of Clinical Quality	Sheila Smith
Medical Director	Professor Lindsay Thomson
Personal Assistant to Corporate Services	Julie Warren [Minutes]

1 APOLOGIES AND INTRODUCTORY REMARKS

Ms Fallon welcomed everyone to the meeting, and apologies were noted from Stuart Currie, Non Executive Director, and Dr Khuram Khan, Consultant Forensic Psychiatrist.

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 11 NOVEMBER 2022

The Minutes of the previous meeting held on 11 November 2023 were noted to be an accurate record of the meeting.

The Committee:

1. Approved the minute of the meeting held on 11 November 2023.

4 MATTERS ARISING

The Chair requested an update in relation to agenda item 16, as a potential matter of concern, and therefore requested an update on the two patients currently on the transfer list post the twelve-month mark. Professor Thomson provided a detailed update for the benefit of the Committee, whereby she reiterated she was content as Medical Director that progress was being made via the

legal processes and there were no clinical concerns for delay.

Ms Fallon also queried access to the intranet for Non-Executive Directors. Ms Smith advised that an update could be provided at the next Board Seminar, scheduled to be held on 16th March 2023.

Lastly, Ms Fallon queried whether Clinical Model Flash reports could be issued to Non-Executive Directors as and when available, rather than waiting a quarter to be presented at Committee meetings. Ms Merson agreed to take this forward on a monthly basis.

Action: Monica Merson

There were no other additional urgent matters which arose for discussion.

5 PROGRESS ON ACTION NOTES

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

Members were content to regard all actions as complete and closed.

The Committee:

1. Noted the updated action list.

6 PSYCHOLOGICAL THERAPIES 12 MONTHLY REPORT

Ms Liz Flynn, the new Head of Psychology, as of January 2023, joined the meeting to present the Psychological Therapy Service Annual Report from January until December 2022, which also highlighted data regarding core activities of the Psychology department, key performance indicators and quality assurance and improvement activity as well as performance objectives for the following year.

Ms Flynn provided an overview of the report and highlighted, in particular, the impact on service delivery over the last review period due to a number of staff vacancies within the service which impacted on the provision of core activities which had not yet returned to pre-pandemic levels. The appointment of the new Health Psychologist proved beneficial and has had a positive impact within the department. The neurodevelopmental pathway was also been taken forward in a positive manner with the final report being prepared at this time. Lastly, in terms of the Sexual Harm Service, she advised that the Moving Forward 2 Change (MF2C) programme was being delivered within the prison and community setting and the Psychology Service were looking to adapt and implement this within the State Hospital, with relevance to patients who have committed sexual offences.

Mr McConnell noted the comparison against last year's planned QA QI Activity and requested further detail on the characteristics of the 'partially completed' Life Minus Violence programme which commenced in December 2021 and was due to run until July / August 2023. Ms Flynn advised that due to the high intensity of the programme and resources required, it was not possible to provide and run two groups simultaneously. She further advised that approximately 3000 clinical sessions had been delivered per annum, prior to the pandemic. At the current time, approximately 2000 sessions were being delivered though the department were aiming to increase this figure.

Mr Moore requested additional detail around the Health Psychologist role and recognised that it would be helpful to view the impact made on the service to date, since commencement of the post in October 2022. Ms Flynn advised, that a detailed summary would be provided within the next report update.

Action: Ms Liz Flynn

He further requested clarity of the role of the Consultant Nurse within the team. Professor Thomson highlighted this was a pre-existing post and was split with the Forensic Network Service. She emphasized that the role was key to the organisation and of the importance of delivery of psychological therapies from previous members of nursing staff who had expert skills in this area. It was also acknowledged that roles such as these provide a career path for qualified nurses where their expertise could be utilised in other areas; and to maximise the use of resources available from within the hospital and the opportunity to upskill staff.

Ms Fallon acknowledged the quantitative narrative with the report and expressed the view, on behalf of the Committee, to support the delivery of the Neurodevelopmental plan and pathway. She requested that further context be provided in a future report of the overall qualitative elements of this pathway following the recent working group establishment and progress made in this area. It was agreed that this should be within the next three to six months.

Action: Ms Liz Flynn

Ms Fallon thanked Ms Flynn for the thorough report and acknowledged the extensive services offered throughout a difficult period. She welcomed additional information in a future update report.

The Committee:

1. Noted the Psychological Therapies Annual Report.

7 CLINICAL GOVERNANCE GROUP 12 MONTHLY REPORT

Members received and noted the Clinical Governance Group 12 Monthly Report, covering the period January to December 2022 and detailing the overall delivery of the two strategic aims i.e. (1) to deliver safe, effective and person-centred care based on available evidence and best practice, and (2) to achieve demonstrable improvements in outcomes including the patient experience.

Ms Sheila Smith provided an overview of the report and highlighted main key areas and progress made in this respect, as well as the work in progress against the four actions identified in respect of the work ongoing to support the Triangle of Care work.

Mr Moore noted the comprehensive report and queried whether there were any fundamental changes to the approach to the Corporate Training Plan to the report the Board received in relation to Statutory and Mandatory training. Professor Thomson advised that the Corporate Training Plan was the basis of this report and that the Clinical Governance Group would identify any gaps and any training priorities for clinical practitioners. To that note, Mr Jenkins suggested that it might be beneficial to review the update provided to the Staff Governance Committee and align this in to one single process.

Action: Mr Gary Jenkins / Ms Margaret Smith / Ms Linda McGovern

Mr Moore further queried in terms of the tableau initiative, if this required additional input from staff and whether this would prove more time consuming, and whether staff views could be captured in this area. Ms Sheila Smith advised that the tableau system pulled information from the input on the electronic patient records system (RiO) and was therefore not new or additional information to be entered, although the system was being reviewed to streamline the information available in RiO, whilst acknowledging any potential of duplicate information.

Mr McConnell referred to page seven, item 2.11, Exceptional Circumstance Finance Report and expressed the view that he had thought the recovery plan was further advanced than was noted. Mr McNaught advised that he and Mr Jenkins met with Health Boards to seek clarity on outstanding amounts from other NHS Boards. Mr McNaught advised that the data were as up to

date as possible. Mr Jenkins further advised that this was also formalised as an approach with the respective Health Boards and would be taken forward at Board Chief Executive meetings.

Ms Fallon queried the reasoning for not utilising the BRAN questions within the hospital at this time and whether engagement with patients was occurring, and if not, what format was being used. Professor Thomson advised this was related to appointments with the General Practitioner or other disciplines and the hospital were keen to have a framework for each profession with a much greater explanation to patients on what the hospital does and why. She advised it was hoped this would be developed further with the Clinical Model work alongside existing mechanisms in place to support decisions and treatment.

The Chair thanked the Clinical Quality Team for the extensive detailed report which was of great benefit to the Committee in terms of reassurance on the delivery of strategic quality aims.

The Committee:

1. Noted the Clinical Governance Group Annual Report.

8 LEARNING FROM FEEDBACK REPORT – QUARTER 3

Members received and noted the Learning from Feedback Quarterly Report (Q3 of 2022/2023) which provided the Committee with an overview of activity related to feedback for the third quarter of the financial year 2022/23 (1 October to 31 December 2022). Mrs Dickson, provided members with a brief summary of the report and highlighted the following areas in terms of feedback shared relating to concerns and a number of themes identified;

- Value placed on activity and frustrations relating to limited access to activity because of resourcing challenges.
- Anxiety around refreshed Clinical Model.
- Inconsistencies with meal times and being provided hot drinks.
- Prioritisation of visits in the Family Centre.

It was reported that there was a significant reduction in the volume of concerns shared this quarter however it was noted that some frustrations continue to be shared around a lack of access to activity. Feedback relating to 'staff attitude' re-emerged this quarter with the Lead Nurses proactively engaged in addressing this. Patients had also highlighted anxieties relating to forthcoming changes relating to the Clinical Model with these concerns being very much at the forefront of the work of the Clinical Model Implementation Group, through which patients were kept fully informed of progress.

Compliments were shared including an increase in travel expenses for carers, a memorial service for patients and the opportunity for the Hospital choir to perform in front of an audience.

Mr McConnell queried the narrative on page five, item 6, relating to nurse attendance at the Patient Partnership Group, and if this was pertinent to all members of ward nursing staff. Ms Dickson advised, on behalf of the patients, that their wish was to extend an open invite to all members of nursing staff to the Patient Partnership Group. Ms Dickson advised it was thought best make a start with nurses in leadership roles.

Mr McConnell referred to page eight, item 14, where it was reported that numerous concerns regarding staff attitudes were highlighted at the Patient Partnership Group. The report indicated this was mainly in relation to patients spending time within their bedrooms and not being provided with hot drinks during times of ward closures. Ms Dickson advised that the Activity Oversight Group was monitoring this with data being provided by the Clinical Quality Team. Lead Nurses were notified if there were concerns for any individual patient. .

Mr Moore requested additional information around issues raised from carers in order to gain a

fuller overall picture of comprehensive views from this important cohort. Ms Dickson agreed and advised that the Person Centred Improvement Advisor was actively working on a carer project and this information would be included in future reports.

Mr Moore also queried whether it was sustainable for PCIT staff to continue to support patient activity, and whether it was related to staff shortage issues. Ms Dickson advised it was sustainable at this time however, this would be kept under review with the introduction of clinical model. Mrs McCaffrey further advised that work was being progressed through the Workforce Governance Group on staffing across the site, and the relation to delivering patient activity. This included delivering multi-disciplinary care in new ways.

The Chair welcomed the overall update on effective feedback in terms of ensuring that patient and or carer experience informed service delivery and took assurance in this regard.

The Committee:

1. Noted the Learning from Feedback Report, pertained to Quarter 3, and its relevance, in terms of ensuring that patient and or carer experience informed service delivery.

9 LEARNING FROM COMPLAINTS REPORT – QUARTER 3

Members received and noted the Learning from Complaints report presented by Ms Margaret Smith, Head of Corporate Governance and Board Secretary.

The report provided an overview of activity of complaints, concerns and enquiries for the third quarter of the financial year 2022/23. The report also detailed the complaints received, the stages at which they were handled, as well as complaints closed within this period.

Ms Smith provided a high level account of the content of the report and provided additional assurance on the following key areas;

1. The reasoning behind why a small number of stage 1 and 2 investigations were not responded to within the national target response times due to responses requiring detailed, lengthy investigation including numerous staff interviews to ensure each concern was investigated thoroughly.

2. The ongoing work with Security Department taking forward the possibility of recording patient calls following a media leak.

3. The Estates Department taking forward the issue with recorded mail and franking system fault.

4. The positive learning gained and improvement on practice to record patient belongings.

Lastly, Ms Smith noted that feedback would be brought back to the next meeting around patients expressing the view of not feeling confident of reporting issues via the Complaints process.

Mr McConnell welcomed the report and commended staff for their efforts in resolving complaints in a timeous manner. He noted that in terms of staff attitudes and behaviours, this had doubled from the previous year and queried if the reasoning for this was due to a particular pattern or whether the answer was in the detail for each case. Ms Smith offered the view that there did not appear to be any particular reason for this and that there was a moving feast element to the complaints process, as the patient population changed over time and this was impactful on the type of complaints received.

Mr Moore made reference to page 9 and the allegation of assault which was reported to Police Scotland at the request of the individual patient and whether there were any additional issues raised

from this. Professor Thomson provided overall detail of this case and advised that each patient has the right to report allegations to Police Scotland and that there was no further action required by the hospital in this matter.

Ms Fallon acknowledged the low number of complaints received in respect of staff shortages and hoped that patients did not accept ward closures / modified ways of working as becoming the norm, hence not reporting their concern. Professor Thomson acknowledged this comment and echoed that a development of that nature would be of concern. Mrs McCaffrey added that there was key focus on staffing resourcing to best support care delivery.

Lastly, Professor Thomson acknowledged the work ongoing on the Supporting Healthy Choices agenda to ensure patient meal times were not compressed and the audit work involved to measure success in this area and ensure mealtimes be adhered to in line with the Standard Operating Procedure in place.

The Chair commended Ms Smith and Complaints and Legal Claims Officer on their very comprehensive report and thanked them for the extensive work by the department.

The Committee:

1. Noted the Learning from Complaints Report, pertaining to Quarter 3 and its relevance, in terms of ensuring areas of improvement and learning taken.

10 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 third 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 1 October to 31 December 2022.

Professor Thomson provided an overview of the content and advised that during this quarter, one patient tested positive for illegal substances. The Security Department took forward their own investigation around this and a concern was raised around possible contamination, which could be due to exposure to a variety of sources. Professor Thomson highlighted the possibilities and reasons for this and that Clinical Security Liaison Managers are taking forward the importance of ensuring staff hands were washed immediately prior to carrying out testing and currently doing the tests. Given the two issues around contamination and previous issues noted around the laboratory, the Committee acknowledged these factors and that whilst there were no concerns arising from this, were supportive of the move to the new laboratory in Glasgow.

Mr Jenkins echoed this and advised that the change of laboratory would provide more assurance of the system of testing overall.

Members acknowledged the extensive in-depth narrative contained within the report and took assurance from the tracker.

The Committee:

1. Noted and approved the content of the Incidents and Patient Restrictions Report, pertained to Quarter 3 2022/23.

11 SAFE STAFFING REPORT

Members received and noted the Safe Staffing Report which covered the period October to December 2022. Ms McCaffrey, highlighted key areas of note from the report highlighting that reporting to this committee would be focused on any clinical impacts related to staffing, with wider workforce reporting being routed through the Staff Governance Committee. She noted for

information of the Workforce Governance Group, that the report included a copy of the Terms of Reference. She noted that the State Hospital had been accepted as an early implementer of safe staffing legislation, and related reporting. Further, that internal auditors were carrying out an audit on workforce reporting as part of the internal audit plan.

Mr Moore queried what opportunities were available for band three nursing staff, to which Ms McCaffrey advised that the hospital support OU Learning, and this process had been improved recently to ensure that staff who qualified would be offered a band 5 role.

Mr Moore asked if staffing deficits were related to the number of vacancies or if staff absence due to sickness was having an increased impact. Ms McCaffrey advised that sickness absence had made an impact over the reporting quarter and an additional factor had been that some staff were signed up to agencies to obtain premium rate shift cover elsewhere, so this should be taken in to account. Ms Fallon followed this up by querying whether staff may be breaching the working time regulations carrying out agency work. Ms McCaffrey advised that there was no opportunity to monitor this information given that it was outwith the hospital.

Ms Fallon noted that it would be helpful for the report to include an outline of the impacts that staffing deficits were having on patient care, with narrative to describe this focused on the qualitative aspects. It was agreed that Ms McCaffrey and Ms Govern would liaise with the Chairs of the Clinical and Staff Governance Committees to ensure reporting around workforce and clinical impacts were routed appropriately going forward.

Action: Ms Karen McCaffrey / Ms Linda McGovern

The Committee:

1. Noted the Safe Staffing Report for Quarter Three.

2. Requested further review of the reporting routes.

12 COVID-19 REPORT

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

Professor Thomson advised that since the last report in November 2022 there had been no wards closed due to outbreaks during the reporting period, although there had been positive Covid-19 patient cases as detailed in the report. Of note, she advised there had been nine patients who had tested positive for Flu A from December 2022.

Mr Moore queried if there were any current issues around staff uptake of the Influenza vaccine. Professor Thomson advised that data are unable to be captured if vaccine was taken within the community setting.

In terms of the recommendation to stand down future Covid-19 reporting, the Committee agreed to stand down this reporting as of today's meeting. Committee secretariat agreed to update the respective Work plan.

Action: Ms Julie Warren

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.

2. Agreed that the Covid-19 Report be stood down as it is no longer required at this time.

13 CORPORATE RISK REGISTER – CLINICAL UPDATE

Members received and noted the Corporate Risk Register clinical update which was presented by Professor Thomson. She provided specific updates on the main points from the report which included updates on CE15 – Impact of Covid-19 Inquiry, ND71 – Failure to assess and manage the risk of aggression and violence effectively and ND70 - Failure to utilise our resources to optimise excellent patient care and experience, HRD112 – Compliance with PMVA Refresher Training, MD30 – Failure to prevent / mitigate obesity.

Ms Fallon made reference to page two, ward closures and asked what actions were taken following these. Professor Thomson advised that the Clinical Quality Team look to review what activities were carried out, or otherwise and how this affected the patient cohort.

The Committee:

1. Noted the reviewed current clinical Corporate Risk Register.

2. Accepted it as an accurate record.

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

14 DISCUSSION ITEM – CLINICAL MODEL UPDATE

A presentation which provided an overview of the implementation works taken to date was delivered by Dr Howitt. Dr Howitt advised that the presentation was prepared in conjunction with Ms Merson, Head of Planning and Performance.

Ms Merson provided thorough updates on key areas such as:

- Details of the four sub specialties and benefits and intentions aimed to be achieved through the new model, such as increased patient physical activity for the betterment of their physical health, feeling of progression for patients, effective use and deployment of available resources, enhanced treatment environment with a more tailored and individualised approach.
- Clinical guidance updates which included key treatment and recovery objectives and process, definition and purpose, structure, admission and transfer criteria, staffing, procedural and security guidance, activity aims, care planning and risk assessment and outcome measures / KPI's. Work was being progressed by each of the four multidisciplinary groups formed in November 2022 to take forward the clinical guidance for each service.
- Patient engagement remained a regular topic of discussion featured at the Patient Partnership Groups. It was also acknowledged that all patients had now had a 1:1 discussion with their Responsible Medical Officer, or deputy, regarding whether they were moving or not, which was followed up by a letter detailing overall information. It was further noted that all patient carers were issued a letter providing them with the same details and that engagement with Advocacy and PCIT took place around supporting patients at this time.
- Other key current work strands involved were contingency planning and arrangements, key mapping works taken forward in terms of beds for the male mental illness population and the process for movement of patients.
- Lastly, in terms of service leadership, it was noted that discussions had taken place to describe and scope responsibilities of the hubs alongside a proposed interim approach to support the stand-up of the new services in development.

The Committee received this very comprehensive overview presentation very warmly and found it helpful in supporting understanding the extensive work carried out which provided assurance.

Mr McConnell commented on the possible overspill of major mental illness beds in to the intellectual disability service and if contingencies for this possible scenario had been discussed and were in place. Ms McCaffrey advised that the possible scenario had been discussed and Lead Nurses were taking forward a step-by-step guide which would include patient experiences following the moves.

In light of the planned staff moves, Mr Moore queried whether there was any feedback or views captured from staff at this time. He also commented on whether there was any expected risk of resistance from patients in line with the anxiety of ward moves. Ms McCaffrey acknowledged the unsettling period for both staff and patients and that moves would be made incrementally, and in partnership with patients and based on advice from their clinical teams. The placement of patients within the new services was based on clinical decision-making.

Ms Merson noted that the changes were being coordinated to try and ensure patients would move with peers if possible, and with full involvement of clinical teams including key workers. Carers were also being kept fully informed and had been advised of where the patient would be placed within the new services at the same time as patients had been advised.

Professor Thomson echoed the earlier update from Ms Merson in that partnership working was ongoing with Clinical Teams, Patients Advocacy Service and the Person Centred Improvement Team to support any anxieties from patients. Given the faced paced work involved, any potential issues or risks would be addressed as and when they were raised. Lastly, it was acknowledged that to date, no patients had expressed their refusal to move wards. Professor Thomson acknowledged the period of increased risk due to change and increased anxiety levels, though reminded members of the origins of the development of the new model especially patient desire for clearer elements of transition and support for the new model from the Mental Welfare Commission.

Members thanked those involved in this area of extensive work and for the very interesting and reassuring presentation.

The Committee:

1. Noted the presentation on Clinical Model as was delivered.

15 COMMITTEE SELF-ASSESSMENT

The Committee received and noted the Self-Assessment Report which was presented by Ms Margaret Smith. She gave an overview of the content of the report following the Committee survey which was circulated in January and focused on setting the direction, holding to account, assessing risk, engaging stakeholders and influencing culture.

Members noted the review findings of the self-assessment and considered the feedback provided on its performance, in terms of utilising it to continue developing the committee and its conduct of business, as well as helping to inform the Committee's Annual Report to the Board for the current

Ms Fallon acknowledged that in terms of assessing the risk, the inclusion of clinical risks from the Corporate Risk Register as a standing item on the committee agenda provided comfort in this area.

The Committee:

1. Noted and reviewed the findings of the Self-Assessment, specific to the Clinical Governance Committee.

16 AREAS OF GOOD PRACTICE / AREAS OF CONCERN

The Committee received and noted the update document on Areas of Good Practice and Matters of Concern for 2022/23. Members agreed there were no additions or amendments required.

The Committee:

1. Noted the Areas of Good Practice / Areas of Concern document.

17 COMMITTEE WORKPLAN

Members received and noted the Committee Work plan for 2022/23. In line with previous agreements recorded above, the following was summarised and the Workplan would be updated to reflect changes made;

1. Stand down of Covid-19 Report and its removal from the Workplan going forward.

2. Narrative on 'Workforce Governance Report' to be correctly reflected and retitled as 'Safe Staffing Report' (clinically focused).

3. Addition to Workplan to include standing item titled 'Sharing any relevant points with Board Committees'. This would also be taken forward and included in Audit and Staff Governance Committee Agenda's.

4. Agreement that a Psychological Therapies six monthly update report be presented in August 2023 by Ms Liz Flynn, Head of Psychology.

5. Agreement that Clinical Model updates would feature as a standing agenda item.

Action: Julie Warren

The Committee:

1. Noted and approved the Clinical Governance Committee Workplan following the updates required as detailed above.

18 ANY OTHER BUSINESS

Members raised no other items of other business.

19 DATE OF NEXT MEETING

The next meeting would be held on Thursday 11 May 2023 at 0945 hours via Microsoft Teams.

The meeting concluded at 1230 hours

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 June 2022
Agenda Reference:	Item No: 15
Sponsoring Director:	Director of Workforce
Author(s):	Director of Workforce
Title of Report:	Staff Governance Committee Annual Report
Purpose of Report:	For Decision

1 SITUATION

The attached Staff Governance Committee Annual Report outlines the key achievements and key developments overseen by the Committee during 2022/23. The stocktake also includes the Committee's Terms of Reference, Reporting Structures and Work Programme.

2 BACKGROUND

Staff Governance is defined as **'a system of corporate accountability for the fair and effective management of all staff.'**

The Staff Governance Standard (4th Edition) sets out what each NHS Scotland employer must achieve in order to improve continuously in relation to the fair and effective management of staff. Implicit in the Standard is that all legal obligations are met, and that all policies and agreements are implemented. In addition to this, the Standard specifies that staff are entitled to be:

- well informed;
- appropriately trained and developed;
- involved in decisions;
- treated fairly and consistently; with dignity and respect, in an environment where diversity is valued;
- provided with a continuously improving and safe working environment, promoting the health and wellbeing of staff, patients and the wider community.

3 ASSESSMENT

In the performance year 2022/23, The State Hospitals Board for Scotland's Staff Governance Committee continued to focus its monitoring activities in respect of the above. The Committee members recognised their obligations to support a culture within The State Hospitals Board for Scotland where the delivery of the highest possible standard of staff management is understood to be the responsibility of everyone working within the organisation and is built upon the principles of partnership.

The Staff Governance Committee approved this report at its meeting on 18 May 2023.

4 RECOMMENDATION

Board Members are asked to approve the Staff Governance Committee Annual Report, as demonstrating that the committee has met its remit and terms of reference during 2022/23.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	To demonstraste that the committee has carried out its remit.
Workforce Implications	N/A
Financial Implications	N/A
Route To Board Which groups were involved in contributing to the paper and recommendations.	Staff Governance Committee Audit Committee
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.

THE STATE HOSPITALS BOARD FOR SCOTLAND

STAFF GOVERNANCE ANNUAL REPORT

1 April 2022 – 31 March 2023

1. INTRODUCTION

Staff Governance is defined as **'a system of corporate accountability for the fair and effective management of all staff.'** The Staff Governance Standard (4th Edition) sets out what each NHS Scotland employer must achieve in order to improve continuously in relation to the fair and effective management of staff. Implicit in the Standard is that all legal obligations are met, and that all policies and agreements are implemented. In addition to this, the Standard specifies that staff are entitled to be:

- well informed;
- appropriately trained and developed;
- involved in decisions;
- treated fairly and consistently; with dignity and respect, in an environment where diversity is valued;
- provided with a continuously improving and safe working environment, promoting the health and wellbeing of staff, patients and the wider community.

In the performance year 2020/21, The State Hospitals Board for Scotland's Staff Governance Committee continued to focus its monitoring activities in respect of the above. The Committee members recognised their obligations to support a culture within The State Hospitals Board for Scotland where the delivery of the highest possible standard of staff management is understood to be the responsibility of everyone working within the organisation and is built upon the principles of partnership. Members of the Staff Governance Committee are appointed annually by the NHS Board. Membership details of the Committee during 2020/21 are detailed below.

2. COMMITTEE CHAIR MEMBERS AND ATTENDEES

Committee Chair:
Pam Radage (Chair of Committee, Non Executive Director)

Committee Members:
Allan Connor (Employee Director)
Stuart Currie (Non-Executive Director)
Cathy Fallon (Non-Executive Director)
Brian Moore (Chair of Board/ Non-Executive Director)

In attendance:
Alan Blackwood (lay member, Prison Office Association)
Gary Jenkins (Chief Executive)
Linda McGovern (Director of Workforce)
Michelle McKinlay (lay member, UNISON)
Monica Merson (Head of Corporate Planning and Business Support)
Margaret Smith (Board Secretary)

Where required by the Chair or by other members of the Committee, appropriate members of staff were invited to be in attendance for the purposes of verbal updates, information sharing and presentations.

3. MEETINGS DURING 2022/23

During 2022/23 the Staff Governance Committee met on four occasions, in line with its terms of reference (Appendix 1). Meetings were held on:

19 May 2022
18 August 2022
17 November 2022
16 February 2023

Attendance of Committee members were as follows:

Date	Pam Radage	Brian Moore	Stuart Currie	Cathy Fallon	Allan Connor
19 May 2022	√	√	√	√	√
18 August 2022	√	X	√	√	X
17 November 2022	√	√	√	X	√
16 February 2023	√	√	√	√	√

4. REPORTS CONSIDERED BY THE COMMITTEE DURING THE YEAR

The Committee received reports and monitored areas as follows:

- Monitoring of Personal Development Planning & Review (PDPR) performance
- Monitoring of Attendance Management performance
- Monitoring HR Performance – Employee Relations Activity
- Monitor the update of iMatter, the NHS Scotland Staff Engagement Tool
- Healthy Working Lives (HWL)
- Workforce Planning
- Whistleblowing
- Statutory and Mandatory Training Compliance
- Fitness to Practice
- Recruitment
- NHSScotland Staff Governance Standard Monitoring Framework
- Wellbeing
- Occupational Health Review and Tender Process
- Practice Development

4.1 ANNUAL REPORTS

Staff Governance Monitoring 2021/22

Staff Governance Monitoring return for 2021/2022 was sent to the Scottish Government by the deadline date of 18 November 2022. This was approved by Staff Governance at their meeting on 17 November 2022.

Positive feedback has been received from the Scottish Government in relation to this return and work will continue to improve the outcomes for Staff (Appendix 2).

iMatter

Members of the committee received an update on 17 November 2022 meeting and received the iMatter End of Year Report (2022-2023) at the February 2023 meeting. They were advised that the response rate was lower than in previous years, but higher than for the Everyone Matters Pulse Survey. It was thought this was due to pressures of staff time and availability due to the Pandemic. Work continues to ensure the response rate rises for the forthcoming cycle.

Occupational Health Service Annual Report

The annual report was presented to the November 2022 meeting by the Occupational Health Clinical Team from SALUS, the current provider of the OHS service level. Key priorities were highlighted and discussed at length, including:

- Service Provision – an overview of all services provided
- Key Priorities
- Quality systems, processes and advice
- Key Performance Indicators
- Measures of performance
- Reducing Absence
- Service Level Agreement Extension and Renewal

4.2 PROGRESS UPDATES

The committee received regular updated reports and monitored issues relating to the following:

- Personal Development Planning & Review (PDPR)
- Attendance Management
- HR Performance – Employee Relations Activity
- Healthy Working Lives / Wellbeing
- Occupational Health Tender

PDPR, Personal Development Plan

Monitoring of completion rates for the Personal Development Planning & Review process was kept under scrutiny throughout the year and reported regularly to Staff Governance Committee as well as Corporate Management Team and Partnership Forum. The average monthly completion rate for 2022/23 was 83.5% - a decrease of 1.7% when compared to the previous year. The PDPR process and associated compliance was impacted by staff absence, and associated capacity and staff availability, which made it difficult at times throughout the year for departments to complete appraisals that were due or overdue. The compliance level at 31 March 2022 was 80.8%.

Attendance Management

The attendance target set for The State Hospitals Board for Scotland in 2022/23 is 5%. This was not reached, with an end of year average monthly absence percentage of 7.45%. The long/short term split is 5.66% and 1.79% retrospectively.

The principal reasons for absence remained consistent with the previous year, with the two most common reasons for absence being anxiety/stress/depression, accounting for 29.2% of absence, and musculoskeletal (injury/fracture, back problems and other MSK), accounting for 24.21% of absence.

Work will continue on analysing any trends such as any links between recruitment issues, increased absence and overtime usage to ascertain any impact on Sickness Absence.

HR Performance – Employee Relations Activity

These reports continue to be presented for information and discussion due to the historic time delays experienced with HR cases, however the Committee recognised improvement in this area.

The Committee discuss the improvements made from previous years, particularly around compliance with policies. This continues to be a focus for the Committee.

Staff & Volunteer Wellbeing Strategy 2022-2024

A Staff & Volunteer Wellbeing Strategy 2022-24 was developed and approved by Board and Staff Governance in May 2022. Updates are provided at every meeting on the actions and development of KPI's for this Strategy with regular reviews being undertaken.

A HR and Wellbeing Group led by the Director of Workforce, established in December 2020, was formed to provide a Forum to review HR and Wellbeing performance, approve TSH implementation of national terms and conditions and programmes of work to enhance Employee Wellbeing.

HWL is a multi-disciplinary group which continues to support work around health and wellbeing across the organisation through the delivery of a varied programme of events and initiatives. They report direct to the HR & Wellbeing Group and regular updates are provided on their workplan and also financial requests from the HWL Budget.

The HWL Group's mission is to provide a forum where health, safety and wellbeing issues can be identified, and strategies put in place to create improvements that result in a happier, healthier and more highly engaged workforce.

Occupational Health Tender Process

The State Hospital has a specific requirement for the provision of Occupational Health and Safety Services to support our statutory obligations as a service provider and an employer. The Service Level Agreement which was in place was led by SALUS and was due to end on 31 March 2023.
A SLWG was established from the HR & Wellbeing Group and reported to Staff Governance at their quarterly meeting. Although the overall finances involved did not require a full tender to be undertaken, it was decided that this process should be followed to allow transparency of the process. The Chair of Staff Governance was involved in the tender panel looking to make the final recommendations to the Board via HR & Wellbeing.

The new provider is NHS Dumfries & Galloway who took over from1 April 2023. This provision is for a 2 year period with a possible extension by mutual agreement. Work will continue on development of the KPI's and these will be reported to Staff Governance.

4.3 STANDING ITEMS CONSIDERED BY THE COMMITTEE DURING THE YEAR

Fitness to Practise

A report was provided in May 2022 to assure the Staff Governance Committee that all professional staff were registered and fit to practise.

Whistleblowing Quarterly updates

Following the implementation from The Scottish Public Services Ombudsman (SPSO) the role of the Independent National Whistleblowing Officer (INWO) commenced from April 2021. The Whistleblowing Standards that SPSO developed was a model procedure for handling whistleblowing concerns raised by staff and others delivering NHS services, was also formally published on 1 April 2021. For NHS Scotland staff, these form the 'Once for Scotland' Whistleblowing Policy.

The Committee received quarterly reports on the following dates:

19 May 2022	-	Quarter 4 Update for 2021/22 and Annual Report for 2021-22
18 August 2022	-	Quarter 1 update for 2022 and Action Plan
17 November 2022	-	Quarter 2 update for 2022
16 February 2023	-	Quarter 3 report and Quarter 4 / Annual Report for 2022-23

Statutory and Mandatory Training

The Committee reviewed the arrangements for completing Statutory and Mandatory training in order to ensure that these were robust, compliant with legislative requirements, and supported the Staff Governance Strand of the workforce being "Appropriately trained and developed".

Notes of Minutes from other meetings

The Committee received and noted minutes/reports from the following:

- Partnership Forum
- Human Resources and Wellbeing Group
- Clinical Governance papers (as appropriate and where related to a Staff Governance issue)

5. CONCLUSION

The performance year 2022/23 has underlined the continuing need to focus our attention on key Staff Governance issues.

The main priority area in terms of Staff Governance performance management continues to be the pursuit of the Attendance Management target of 5% absence and issues around Recruitment & Retention. Another key priority however is the emerging wellbeing agenda for Staff and Volunteers and work will continue in this area to ensure support and guidance is readily available.

From the review of performance of the Staff Governance Committee, it can be confirmed that the Committee has met in line with the Terms of Reference, and has fulfilled its remit. Based on assurances received and information presented to the Committee, adequate and effective Staff Governance arrangements were in place throughout the year.

I offer my thanks for the continuing support and encouragement of Committee members and also to those members of staff who have worked on the Committee's behalf during 2022/23**.**

Pam Radage
STAFF GOVERNANCE COMMITTEE CHAIR
On behalf of the State Hospitals Board for Scotland Staff Governance Committee

THE STATE HOSPITALS BOARD FOR SCOTLAND

STAFF GOVERNANCE COMMITTEE
TERMS OF REFERENCE

1 PURPOSE

The Staff Governance Committee is a standing committee of the Board and shall be accountable to the Board. Its purpose is to provide the Board with the assurance that staff governance mechanisms are in place and effective within The State Hospital.

2 COMPOSITION

2.1 Membership

The Staff Governance Committee is appointed by the Board and shall be composed of the Employee Director and three other Non Executive Board Members one of whom shall act as Chair.

The Committee can invite the Board Chair to be a member of the committee for the purposes of a meeting, should it be the case that the committee would otherwise be inquorate.

There will be three lay representatives identified by the staff side organisations and nominated by the Partnership Forum. The lay representatives will not act in an ex officio capacity. An ex-officio member is a member of a body who is part of it by virtue of holding another office. Such members shall have the power to vote in the Committee's decisions.

Membership will be reviewed annually.

The Staff Governance Committee will have the authority to co-opt other attendees from outwith the Board in order to carry out its remit.

2.2 Appointment of Chair

The Chair of the Committee shall be appointed at meeting of the Board in accordance with Standing Orders.

2.3 Attendance

Members shall normally attend meetings and receive all relevant papers. All Board Members will have the right to attend meetings and have access to all papers, except where the committee resolves otherwise.

Executive Directors of the Board are not eligible for membership of the Committee. The Accountable Officer (Chief Executive) and Human Resources Director shall be invited to attend meetings and receive all relevant papers. Other Directors and staff may also be invited by the Chair of the Committee to attend meetings as required.

3 MEETINGS

3.1 Frequency

The Staff Governance Committee will meet quarterly to fulfil its remit and shall report to the Board following each meeting.

3.2 Agenda and Papers

The agenda and supporting papers will be sent out at least five working days in advance of the meetings to allow time for members' due consideration of issues. All papers will clearly state the agenda reference, the author and the purpose of the paper, together with the action to be taken. The format of agendas and papers will be in line with corporate document standards. The lead Executive for co-ordinating agendas and papers is the Human Resources Director.

3.3 Quorum

Two members of the Committee will constitute a quorum.

3.4 Minutes

Formal minutes will be kept of the proceedings and, once approved, submitted at the next Board meeting. The Chief Executive's personal assistant is responsible for minute taking arrangements.

The minutes and action list of the Staff Governance Committee will be presented to the next Staff Governance Committee meeting to ensure actions have been followed up.

3.5 Other

In order to fulfil its remit, the Staff Governance Committee may obtain whatever professional advice it requires and invite, if necessary, external experts and relevant members of hospital staff to attend meetings.

If necessary, meetings of the Committee shall be convened and attended exclusively by members of the Committee.

4 REMIT

4.1 Objectives

The main objectives of the Staff Governance Committee are to provide the Board with the assurance that staff governance mechanisms are in place and effective within The State Hospital; and that the principles of the national Staff Governance Standards and The State Hospital's Staff Charter are applied equitably and fairly to all staff.

Existence and effective operation of this committee will be demonstrated in continuous improvement and compliance with staff governance standards, in delivery of improved working arrangements for staff, and ultimately in achievement of outcome targets as evidenced through the staff related key performance indicators reported in the Local Delivery Plan.

4.2 Systems and accountability

4.2.1 To ensure that appropriate staff governance mechanisms are in place throughout the hospital in line with national standards.

4.2.2 To ensure that people management risks are managed in accordance with the corporate risk management strategy, policies and procedures.

4.2.3 To ensure that staff governance issues which impact on service delivery and quality of service are appropriately managed.

4.2.4 To review the Staff Governance Action Plan and ensure that the Partnership Forum is performance managing the action plan.

4.3 People management

To provide assurance to the Board in respect of people management arrangements, that:

4.3.1 Culture is maintained within the hospital where the delivery of the highest possible standard of staff management is understood to be the responsibility of everyone working within the hospital and is built upon partnership and collaboration.

4.3.2 Structures are in place to monitor the outcome of strategies and implementation plans relating to people management.

4.3.3 Structures are in place to monitor the outcome of strategies and implementation plans relating to knowledge management.

4.3.4 Propose policy amendment, funding or resource submission to achieve the Staff Governance Standards.

4.3.5 Support is given for any policy amendment, funding or resource submission to achieve the Staff Governance Standards.

4.3.6 There is timely submission of all staff governance data required by the Scottish Government Health Department and in respect of the Local Delivery Plan.

4.3.7 Pay modernisation processes are monitored and that the Boards Pay Benefits Realisation Plans are signed off.

4.3.8 Workforce planning and development is monitored and to sign off the Boards Workforce Plan and the Boards Development Plan and ensure they support the Local Delivery Plan.

4.3.9 Policies and procedures are developed, implemented and reviewed.

4.4 Controls assurance

To ensure that:

4.4.1 The information governance framework provides appropriate mechanisms for Codes of Practice on Data Protection and Freedom of Information to be applied to all staff.

4.4.2 The planning and delivery of services has fully involved partnership working.

4.4.3 Systems are in place to measure and monitor performance to foster a culture of quality and continuous improvement.

4.4.4 Staff governance information is provided to support the statement of internal control.

5 AUTHORITY

The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

The Committee is authorised to establish a Remuneration Committee to cover staff under executive and senior manager pay arrangements and to validate the work of that committee. The Remuneration Committee must include, as a minimum, three Non Executive Directors of the Board. The Remuneration Committee will be a closed committee and shall sign off its own minutes. The Staff Governance Committee will require to be provided with assurance that systems and procedures are in place to appropriately manage the pay of this group of staff. This will not include detailed confidential employment issues that are considered by the

Remuneration Committee: these can only be considered by Non Executive Directors of the Board.

6 PERFORMANCE OF THE COMMITTEE

The Committee shall annually review and report on:

- Its own performance and effectiveness in meeting the terms of reference; including its running costs, and level of input of members relative to the added value achieved
- Proposed changes, if any, to the terms of reference.

7 REPORTING FORMAT AND FREQUENCY

The Chair of the Committee will report to the Board following each meeting of the Staff Governance Committee.

The Chair of the Committee shall submit an Annual Report on the work of the Committee to the Board.

8 COMMUNICATION AND LINKS

The Chair of the Committee will be available to the Board as required to answer questions about its work.

The Chair of the Committee will ensure arrangements are in place to provide information to the Scottish Government as required to meet their reporting requirements.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 June 2023
Agenda Reference:	Item No: 17
Sponsoring Director:	Director of Workforce
Author:	Director of Workforce
Title of Report:	Remuneration Committee Annual Report – 2022/23
Purpose of Report:	For Decision

1 SITUATION

The attached Remuneration Committee Annual Report outlines the workplan overseen by the committee during 2022/23.

2 BACKGROUND

Staff Governance is defined as 'a system of corporate accountability for the fair and effective management of all staff. The State Hospitals Board for Scotland's Remuneration Committee fulfils this remit with particular regard to the performance, pay and terms and conditions of Executive and Senior Managers.

3 ASSESSMENT

In the performance year 2022/23, the Remuneration Committee continued to focus its monitoring activities in respect of the above responsibilities and provided reporting to the National Performance Monitoring Committee in this regard. The committee also considered the award of Consultant Discretionary Points.

The membership of the committee was reviewed during this year, and the terms of reference were amended to reflect that it will comprise of at least four non-executive directors including the Employee Director and Board Chair. Previously, all non-executive directors were members of the committee.

The Remuneration Committee reviewed and approved this report and the amended terms of reference at its meeting on 8 June 2023.

4 RECOMMENDATION

The Board is asked asked to approve the Remuneration Committee Annual Report, as demonstrating that the committee has met its remit and terms of reference during 2022/23.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Reporting to demonstrate that committee has met its remit
Workforce Implications	No specific proposal to consider
Financial Implications	None Identified
Route To Audit Committee Which groups were involved in contributing to the paper and recommendations.	Submitted for noting, as part of year end reporting, and prior to submission to the Board
Risk Assessment (Outline any significant risks and associated mitigation)	Not required for reporting
Assessment of Impact on Stakeholder Experience	Not required for reporting
Equality Impact Assessment	Not required for reporting
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	No impact identified
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One √ There are no privacy implications. □ There are privacy implications, but full DPIA not needed □ There are privacy implications , full DPIA included.

THE STATE HOSPITALS BOARD FOR SCOTLAND

REMUNERATION COMMITTEE ANNUAL REPORT

1 April 2022 – 31 March 2023

1 INTRODUCTION

Staff Governance is defined as **'a system of corporate accountability for the fair and effective management of all staff.'**

The Staff Governance Standard (4th Edition) sets out what each NHSScotland employer must achieve in order to improve continuously in relation to the fair and effective management of staff. Implicit in the Standard is that all legal obligations are met, and that all policies and agreements are implemented. In addition to this, the Standard specifies that staff are entitled to be:

- well informed;
- appropriately trained and developed;
- involved in decisions;
- treated fairly and consistently; with dignity and respect, in an environment where diversity is valued;
- provided with a continuously improving and safe working environment, promoting the health and wellbeing of staff, patients and the wider community.

In the performance year 2022/23, The State Hospitals Board for Scotland's Remuneration Committee continued to focus its monitoring activities in respect of the above, with particular regard to the performance, pay and terms and conditions of Executive and Senior Managers.

The NHS Board Vice-Chair remains Chair of the Committee which aligns with practice throughout NHS Scotland. This ensures that the committee chair does not play a role in the Executive and Senior Manager Appraisals process, avoiding potential conflict of interest.

2 COMMITTEE CHAIR MEMBERS AND ATTENDEES

During this year, the Board reviewed membership of the Remuneration Committee. At its meeting on 23 February it was confirmed that membership would be as follows:

Committee Chair:

David McConnell, NHS Board Vice-Chair:

Committee Members:

Allan Connor, Employee Director
Cathy Fallon, Non-Executive Director
Brian Moore, NHS Board Chair
Pam Radage, Non-Executive Director

Up until February 2023, Mr Stuart Currie, Non-Executive Director had also been a member.

In Attendance:

Gary Jenkins, Chief Executive
Linda McGovern, Director of Workforce
Margaret Smith, Head of Corporate Governance/Board Secretary

3 MEETINGS DURING 2022/23

During 2022/23 the Remuneration Committee met on three occasions.

Meetings were held on:

- 28 July 2023
- 31 October 2022
- 20 February 2023

Attendance at the committee meetings was as follows:

	No. of meetings present
David McConnell	3
Allan Connor	2
Stuart Currie	0
Cathy Fallon	1
Brian Moore	3
Pam Radage	3

4 REPORTS CONSIDERED BY THE COMMITTEE DURING THE YEAR

- Approval of the Performance Management arrangements and Performance Appraisals for Executive Directors for the performance year 2021-22.
- Agreement that the Appraisal outcomes for Executive Directors be submitted to the National Performance Management Committee.
- Settlement Agreement – considered and endorsed to be submitted to Scottish Government
- Consideration of the National Performance Management Committee's appraisal analysis.
- Agreement of the Executive Directors Performance Planning and Review (Objectives) for the year 2022/23.
- Agreement of the Executive Directors Mid-Year Reviews for 2022/23
- Consultants discretionary points were reported on and approved.
- Approval of Executive and Senior Managers Pay for 2022-23.

The Remuneration Committee also reviewed other issues related to its remit. During this year the committee considered recruitment to Executive and Senior Management positions in the organisation to ensure resilience in the Executive Team.

5 CONCLUSION

The Remuneration Committee discharged its responsibilities with regard to the oversight of Executive and Senior Managers' performance management and remuneration.

I would like to thank the members for their contribution to the work of the committee in 2022/23.

David McConnell
REMUNERATION COMMITTEE CHAIR
On behalf of the State Hospitals Board for Scotland Remuneration Committee

THE STATE HOSPITALS BOARD FOR SCOTLAND

REMUNERATION COMMITTEE

TERMS OF REFERENCE

1 The Committee shall be known as the Remuneration Committee of The State Hospitals Board for Scotland. It will be a standing Committee of The State Hospitals Board for Scotland and will make decisions on behalf of The State Hospitals Board for Scotland.

COMPOSITION

2 The Remuneration Committee members will be appointed by The State Hospitals Board for Scotland and will consist of:

- The Vice-Chair of The State Hospitals Board for Scotland, who will be the Committee Chair
- Four Non-Executive Directors of the Board, including the Employee Director and the Board Chair.

In addition, there will be in attendance (in full or part):

- Chief Executive
- Director of Workforce
- Head of Corporate Governance/Board Secretary

No employee of the Board shall be present when any issue relating to their employment is being discussed.

3 The Director of Workforce will be the Executive Director Lead and will attend meetings of the Remuneration Committee as Advisor.

Executive Director Lead

Generally, the designated Executive Lead will support the Chair of the Committee in ensuring that the Committee operates according to / in fulfilment of its agreed Terms of Reference.

Specifically, they will:

- support the Chair in ensuring that the Committee Remit is based on the latest guidance and relevant legislation;

- liaise with the Chair in agreeing a programme of meetings for the business year, as required by its remit;

- oversee the development of an Annual Workplan for the Committee which is congruent with its remit and the need to provide appropriate assurance at the year-end, for endorsement by the Committee and approval by the Board;

- agree with the Chair an agenda for each meeting, having regard to the Committee's Remit and Workplan;

- oversee the production of an Annual Report, informed by self-assessment of performance against the Remuneration Committee Self-Assessment Handbook, on the delivery of the Committee's Remit and Workplan for endorsement by the Committee and submission to the Board.

4 Where issues with financial implications are to be discussed at the Remuneration Committee the implications will first have been discussed with the Finance Director and, where appropriate, the Finance and Performance Management Director may be invited to attend meetings of the Remuneration Committee.

5 The quorum for the Remuneration Committee will be attendance by 3 Non-Executive Directors, inclusive of the Chair.

FUNCTIONS

6 To oversee and agree the remuneration arrangements and terms and conditions of employment of Executive Directors and Senior Managers of The State Hospitals Board for Scotland, to include:

- content and format of job descriptions
- terms of employment including tenure
- remuneration
- benefits including pension or superannuation arrangements
- annual salary review

7 To ensure arrangements are in place for the assessment of the performance of The State Hospitals Board for Scotland and to monitor the performance of The State Hospitals Board for Scotland against pre-determined performance criteria to inform oversight of objective setting and support for decisions on individual performance appraisal.

8 To agree The State Hospitals Board for Scotland's arrangements for performance management and to ensure that the performance of the Executive Directors is rigorously assessed against agreed objectives within the terms of the performance management arrangements referred to above.

9 To ensure that clear objectives are established for Executive Directors of The State Hospitals Board for Scotland before the start of the year in which performance is assessed by

- receiving a report from the Chair on the agreed Objectives for the Chief Executive
- receiving a report from the Chief Executive on the agreed Objectives for the other Executive Directors of the Board.

10 To monitor arrangements for the pay and conditions of service of other Senior Managers on Executive Pay arrangements and on Professional/Management Transitional pay arrangements in accordance with appropriate guidance and to implement annual pay uplifts and pay progression in accordance with national guidance.

11 To approve The State Hospitals Board for Scotland's arrangements for the grading of Senior Manager and Executive Director posts and to oversee these arrangements by receiving regular reports from the Director of Workforce.

12 To ensure that arrangements are in place to determine the remuneration, terms and conditions and performance assessment for staff employed under the Executive and Senior Management Pay arrangements. To receive formal reports (at least annually) providing evidence of the effective operation of these arrangements.

13 To consider any redundancy, early retiral or termination arrangement in respect of all State Hospital staff, excluding early retirals on grounds of ill health, and approve these or refer to the Board as the Committee sees fit. In addition, the Committee will oversee the award of discretionary points to medical staff.

14 To fulfil its functions, the Remuneration Committee will take into account a range of factors which will include

- regular reports from the Director of Workforce
- the Remuneration Committee Self-Assessment Handbook
- guidance issued by the Scottish Government Health Department
- an annual report on the application of pay awards and pay movements
- the need to recruit and retain appropriately qualified and skilled Directors and Senior Managers
- equitable pay and benefits for the level of work performed

CONDUCT OF BUSINESS

15 Meetings of the Committee will be called by the Chair of the Committee with items of business circulated to members one week before the date of the meeting.

16 The Committee will seek specialist guidance and advice as appropriate.

17 All business of the Committee will be conducted in strict confidence.

REGULARITY OF MEETINGS

18 Meetings of the Remuneration Committee will be held as necessary to conduct its business. At a minimum, the Committee should meet twice per annum, once to approve the performance assessments and annual Objectives of the Executive Directors and once to approve the annual application of pay awards and pay progression.

REPORTING ARRANGEMENTS

19 The Remuneration Committee will report to the Board.

Membership of the Remuneration Committee will be reported to and agreed by the Board. Appropriate details of Executive Members remuneration will be published in The State Hospitals Board for Scotland's Annual Report.

Annual Report

In accordance with Board and Committee Working, the Committee will submit to the Board each year an Annual Report, encompassing : the name of the Committee; the Committee Chair; members; the Executive Lead and officer supports / attendees; frequency and dates of meetings; the activities of the Committee during the year, including confirmation of delivery of the Annual Workplan and review of the Committee Terms of Reference; improvements overseen by the Committee; matters of concern to the Committee.

Where the review by the Committee of its Terms of Reference results in amendment the revised Terms of Reference must be submitted to the Board for approval. The Committee Annual Report will inform the submission of any appropriate assurance to the Chief Executive at the year-end, as part of the Statement of Internal Control.

20 Details of the business conducted by the Committee will be made available to the Scottish Government Health Department, the form and content being determined by the latter.

21 Reporting, marked as 'official sensitive', on each meeting of the Remuneration Committee will be issued to the Non-Executive Directors of the Board.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 June 2023
Agenda Reference:	Item No: 18
Sponsoring Director:	Director of Workforce
Author(s):	HR Advisor / Training & Professional Development Manager / Head of HR
Title of Report:	Staff Governance Report
Purpose of Report:	For Noting

1 SITUATION

This report provides an update on overall work within the Workforce Directorate. This report encompasses all the updates in one rather than the numerous papers in the past.

Information and analysis is provided quarterly to the Staff Governance Committee and Bi-monthly to the Board. Monthly reviews also take place at the Workforce Governance Group, 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

The Workforce Team consist of HR, Learning, Training & Development and Occupational Health.

The Teams work closely together to support Managers and Staff within TSH on a number of key areas and this report details the background and update for each Department.

It was agreed by the Board that the reports should be amalgamated into one regular update.

3 ASSESSMENT

HR UPDATE

Absence and Attendance Management

Hospital Wide

- The information available shows that the absence rate for May 2023 is 8.55% (April 2023 was 8.27%). The rolling year average is 7.97%
- May 2023 Short Term 2.20%. Long Term 6.35%
- Rolling year Short Term 1.78%. Long Term 6.20%

Concerns had been raised at the Staff Governance Committee and it was agreed that a Task and Finish Group would need to be established to resolve attendance management. A Terms of Reference is being developed with the Group meeting on a regular basis and will concentrate on outputs. Updates will be provided to Staff Governance via CMT and Partnership Forum.

Nursing focus

- The information available shows that the absence rate for May 2023 is 11.48% (April 2023 was 10.66%). The rolling year average is 10.42%
- May 2023 Short Term 3.07%. Long Term 8.40%
- Rolling year Short Term 2.06%. Long Term 8.35%

Training/ Support

- The HR team continue to support line managers to offer guidance.
- Attendance Management Training with the Trade Unions took place on 23 May 2023. 17 Line Managers were invited via the learning centre with 5 attending.
- Attendance Management Training for Charge Nurses also took place on 19 May 2023 and 26 May, which focused on return to work interviews and reasonable adjustments. 12 Charge Nurses attended this.
- Positive feedback was received following the training. There was a request for template referrals for OH to be developed for reference as well as further training on the application of special leave training when the Once for Scotland policy is confirmed. In the meantime the HR department are producing reports on special leave utilisation, for mangers to review alongside attendance management data.
- The new Assistant HR Advisor will review return to work interviews compliance as well as the quality of interviews going forward from these sessions and address with the Charge Nurse / Senior Charge Nurses where improvements are required.
- As requested by the Staff Governance Committee, trend analysis will be undertaken to ascertain how we align with other Forensic Services within NHSScotland and also the High Secure Environments in England. Work has already commenced on this and will be presented to Staff Governance at their August meeting.

- Corporate Management Team approved guidance on Reasonable Adjustments following sessions with the Business Disability Forum.
- Corporate Management Team approved the reviewed guidance for Temporary Assignments (where people require an alternative role for a period of time) to ensure a consistent and supportive approach for staff.
- The implementation of the new OH contract continues. There is now a focus on quality referrals (linked to the templates described above), focus on case management for those who require support and maximising attendance at appointments. There are a high proportion of appointments which are rearranged at the request of the employee to a future date which results in lengthened absence from work. This will be a KPI reported going forward.
- Senior Charge Nurses have had the opportunity to meet with Training & Professional Manager alongside HR to review 5 year analysis of their staff and have been asked to meet with all of their team to recognise and commend where there has been positive attendance at work, as well as addressing those with absence higher than the expected standard.
- Sickness Absence will be considered at each of the Quarterly Performance Reviews with Chief Executive.

Attendance Management

- 80 staff are currently being managed through the formal stages of the Attendance Policy.
- For this month 9 staff were placed on monitoring through Stage 1 of the Attendance Policy.

Absence Reasons

- Key reasons for short-term absence were anxiety/stress/depression, cold/cough/flu, chest / respiratory problems, back problems, injuries/fractures and gastrointestinal.
- Key reasons for long-term absence, were anxiety/stress/depression, musculoskeletal, injury / fracture and back problems.

Recruitment

Adverts

- 11 separate posts were advertised in May, totalling 14 vacancies.
- There are three individuals with confirmed starts dates and a further 17 with conditional offers pending pre-employment checks and NMC Pins.
- These are broken down as follows:

A vacancy is generally determined when the approved request form is passed to the Recruitment Team. However, in the future updates we will ask Managers to give us a general update on the establishment and their plans on any future recruitment. This will highlight any change of posts / service review or changing their skill mix.

In terms of current outstanding posts across the Board, we have confimed start dates for 13.06 WTE. We are currently working on the conditional offers and confirmed start dates for 16.06 WTE.

To break this down further, in terms of nursing vacancies included in the above figure, we are currently working with 13 WTE newly qualified Staff Nurses. They will be employed as Band 3 Nursing Assistants until their NMC Registration comes through in September. We currently have confirmed dates for 5 WTE and working on confirming the remaining 8 WTE.

Time to Hire

There are three areas of note where the TSH figure for KPI has improved.

- Job Approval to Live KPI is 2 days. TSH timescale was 1. This has been an improvement on the figure of 3 last month.
- Shortlisting Complete to Invite to Interview KPI is 3 days. TSH timescale was 3 which is an improvement on last months 8.
- Invite to Interview KPI is 7 days. TSH timescale was 13. This could be improved again by arranging interview dates prior to advert.

Recruitment and Retention Strategy

- Corporate Management Team approved the recruitment & retention strategy. The actions from the strategy will be taken forward in a work plan and reported going forward through the Workforce Governance Group.

Supplementary Staffing

Overtime and Excess Hours

- 42.11 WTE supplementary staffing were required through overtime or excess hours for the whole organisation. 26.65 WTE supplementary staffing were 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

ER Case Work

- There are 7 ongoing cases (report says 8 IT ‘glitch’ which we are working on!), three of which have been ongoing for more than six months and timescales have been agreed for progressing these to completion as soon as possible. The reasons for the timescales for have been reported to Corporate Management Team for oversight.
- Since the last report one case has concluded. The timescale for this case was 4 months from notification to the staff member of concerns, until notification of the case concluding.
- Lessons learned from this case will be shared appropriately with the team/s involved.

Focus remains on quality early resolution for employment relations cases where appropriate.

Turnover

Leavers

- 4 staff ended their employment at The State Hospital in May 2023.
- 2 of the 4 staff who have ended employment have returned as part of the Nursing Pool to SSR activity.

Exit Interviews

- Exit interviews are offered to all staff on leaving the organisation at the time of resignation letter received to HR.

14 individuals have completed the exit form in this way to date, providing useful information. Analysis continues to be conducted and work will continue to be reported into the Workforce Governance Group going forward.

eRostering

eRostering is well underway and Teams are currently working through their rosters. There is a plan in place to go through the Hubs and supporting the Teams on using the new system moving forward. It is planned that this will be fully implemented by 31st March 2023.

There are 4 stages to the implementation which are Initiation, Readiness, Deployment, Adoption and Realisation. We are currently in Deployment and will move to Adoption in May before moving to Realisation by end of March 2024.

Some of the agreed national benefits to this programme will be delayed to due to the national work on providing Boards with an interface between eRostering and SSTS which is planned for July at the moment.

The introduction of this new system will offer an opportunity for data to be analysed and viewed at a glance by the Line Managers. They will be able to see any set patterns and highlight this to staff. This includes absence after pay day, weekend absence, public holiday absence or indeed absence just prior to or after a period of annual leave. This will enable Managers to consider areas of concern.

Learning, Training & Development

PDPR Compliance

In line with national targets, a key priority within the State Hospital's Staff Governance Action Plan is to ensure that all staff have an annual Personal Development Planning and Review (PDPR) meeting with their line manager.

As at 31 May 2023:

- The total number of current (i.e. live) reviews was 473 (78.4%) – a decrease of 2.4% from 31 March 2023.
- A total of 111 staff (18.4%) had an out-of-date PDPR (i.e. the annual review meeting is overdue) – an increase of 2.1 from March 2023.
- A further 19 staff (3.2%) had not had a PDPR meeting – an increase of 0.3% from March 2023. Staff in this group are predominantly new staff with an initial set-up review meeting overdue.

There are 14 departments below the State Hospital's 80% minimum compliance threshold (an increase of one from March 2023). Ongoing discussions are taking place with the Training & Professional Development Manager and Director of Workforce. This will also be discussed at each Departments performance meetings.

Progress reports continue to be provided to all departmental managers on a monthly basis, and compliance levels are monitored and reviewed quarterly by the Organisational Management Team. Compliance will also be monitored at the Quarterly Performance Reviews with the Chief Executive.

OD Manager

The newly appointed OD Manager will commence employment on Monday 19 June. This is a full time permanent post. Their initial work will include the development of the Teams linked to the Clinical Model implementation and in particular the Culture work.

iMatter

The 2023 iMatter cycle will commence as follows:

- 24 April - Team confirmation begins
- 22 May - Questionnaire distributed to workforce
- 12 June – Questionnaire closes
- 26 June - Team reports are published
- 22 August - Team action plan completion date

The 2023 questionnaire will feature additional questions to capture whistleblowing concerns. These questions will not impact on the employee engagement index (EEI) but run as a test of change for 2023 with appropriate evaluation of success and impact.

Coaching

There are three internal trained coaches who provide coaching for TSH workforce and work as part of a collaborative coaching network across the West of Scotland.

- We have no members of TSH staff being coached internally by TSH coaches.
- We have six TSH members of staff waiting to be matched by a NHSL coach.
- We have one TSH member of staff being coached by an NHSL coach.
- We have one external staff member being coached by a TSH coach.

Coaching for Wellbeing continues to be available for all H&SC staff across Scotland and registration for this can be accessed via the National Wellbeing Hub.

Team Development

Affina Team Journey - two teams are currently engaged with this development programme.
Core Strengths SDI 2.0 - one group of staff are currently engaged

Wellbeing

Funding approval is now in place for the Wellbeing Advisor post and the SLA with NHS Lanarkshire for the Staff Care Specialist role to continue on permanent basis. Although this will remain as a cost pressure to the Board, this highlights the ongoing support of providing ongoing services for Staff Wellbeing within the TSH and build on the successes to date. Unfortunately the Staff Care Specialist, Lorna Fyfe, left the organisation for a permanent role however NHS Lanarkshire are committed to providing ongoing support as part of their SLA and 2 new Staff Care Specialist will assist.

Graeme Bell and Patricia Johnston have commenced and had a full case handover from Lorna prior to her leaving to ensure as smooth a transition as possible. They will cover on a temporary basis until the post is advertised and recruited to for the 2 days per week support from NHS Lanarkshire. To date, the Staff Care Specialist has received a total of 52 referrals for support.

Whilst retaining confidentiality, it is hoped that key themes coming from these discussions can provide information on the improvements and services moving forward

Staff, volunteers and visitors continue to access the Wellbeing Centre regularly on a daily basis.

The Wellbeing Team are continuing with wellbeing check-ins/visits across all departments, in the shape of Coffee, Cake and Conversation events. So far in May and June we have had 63 staff engage with these events, with more dates planned until end of June:

May/June:

Arran - 10 May
Iona - 12 May

Mull - 15 May
Lewis - 17 May
Security - 18 May
Estates, Procurement and Dining Room - 2 June
Iona – 12 June
Evening Housekeeping - 14 June
Iona – 15 June
Wellbeing Centre - 30 June

The Peer Support Network training is well underway with the final cohort of staff being trained on 16 June. It is anticipated that the Peer Support Network will launch in August with a total of 26 peer supporters which includes members of the Nurse Practice Development Team, Wellbeing Team and staff who applied to become a peer supporter.

Three of six training sessions for 'Supporting a Mentally Healthy Workforce Training for Managers and Leaders' held to date – 20 managers have attended so far. Further training dates have been planned in the 2023/24 training calendar.

The first of four planned on-site relaxation therapy days went ahead on 30 May with 41 members of staff participating. A therapist offered 15-minute chair or Indian head massage appointments in a selected hub and another therapist based in the wellbeing centre offered 30-minute Swedish or remedial sports massage appointments.

Staff were invited to book in for a session and where there were some gaps in the booking sheet, the team were on hand to call around the hospital to maximise attendance. The next scheduled dates for on-site relaxation are:

Wednesday 28 June – Iona and Wellbeing Centre
Thursday 31 August – Lewis and Wellbeing Centre
Thursday 28 September – Arran and Wellbeing Centre

Staff benefit programmes currently being formulated:

- Cycle to Work Scheme launched on 1 May – so far 5 staff have taken up the scheme
- NHS Credit Union – online sessions and marketing for all as well as targeting different staff groups i.e. new starts, retirees, offline staff

4 RECOMMENDATION

Board Members are invited to note this report and the updates.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Links to the Staff Governance Plan, Attendance Management Policy, Mandatory / Statutory Policy.
Workforce Implications	Failure to achieve relevant targets will impact ability to efficiently resource organisation.
Financial Implications	Failure to achieve 5% sickness absencetarget 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, Workforce Governance Group, 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 set targets 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 June 2023
Agenda Reference:	Item No: 19
Sponsoring Director:	Director of Workforce
Author(s):	Director of Workforce
Title of Report:	Workforce Planning Strategy 2022-25
Purpose of Report:	For Decision

1 SITUATION

This paper provides an update on the National Workforce Planning expectations for The State Hospital described in DL(2022)09. The Workforce Plan 2022-25 was developed in line with this guidance.

A letter followed from this dated 5 May 2023, emailed to Boards on 31 May 2023, which detailed that the Workforce Plan update should be provided as part of the Annual Delivery Plan 2023/24 which was due for submission on 8 June 2023.

2 BACKGROUND

On 1st April 2022, Health Boards and HSCPs were issued with guidance from Scottish Government relating to the development of Three-Year Workforce Plans which reflect the National Health and Social Care Workforce Strategy. The guidance constitutes the first iteration of new medium term workforce planning guidance for health and social care, with the express intention of improving the strategic alignment between workforce, financial and service planning. It further requested that the Plan be reviewed and updated by 31 October 2023.

However, information was received by the Board's Planning Leads which indicated that the update from the Workforce Plan 2022-25 should form part of the ADP. The letter was later received by HR / Workforce Directors on 31 May 2023.

3 ASSESSMENT

The Workforce Plan details the five pillars of workforce planning outlined in the National Workforce Strategy. TSH strives to be an exemplar employer; therefore, the development of a supportive culture that puts staff needs and wellbeing central to delivery is essential. This is reflected in the Staff & Volunteer Wellbeing Strategy and Action Plan. The Workforce Plan will also remain under review and updated in line with nationally led changes to terms and conditions such as the implementation of the 36 hour working week, protected learning time, review of nursing profiles and Agenda for Change review.

Work had already commenced on the update of the Workforce Plan which has been included in the ADP 2023/24. The update is as follows:

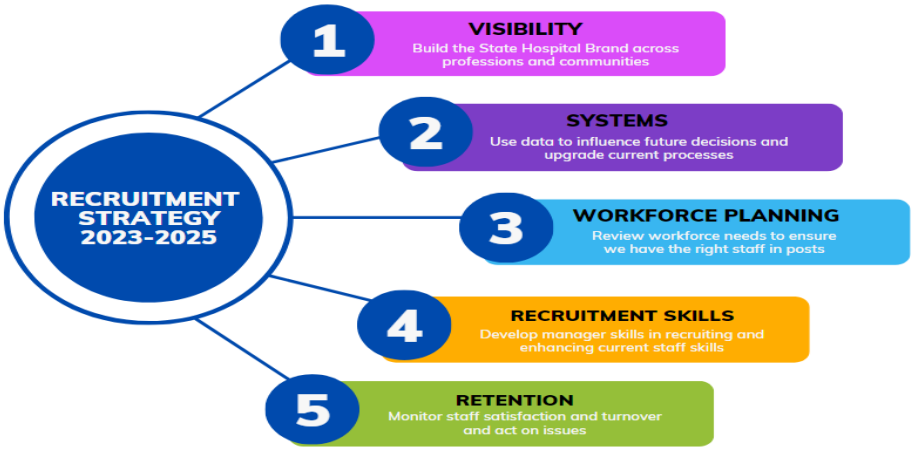
As detailed previously, TSH Workforce TSH Workforce Plan for the period 2022 – 2025 details the Five Pillars of Workforce Planning outlined within the National Workforce Strategy, these are:

1) Plan
2) Attract
3) Train
4) Employ
5) Nurture

The National Strategy details that these should be the basis for action to secure sufficient workforce to meet both short term recovery and medium term growth and transformation in our services and workforce. Therefore, detailed below is progress towards actions achieved in year 1 2022/23 of the plan and outlines proposed work within each of the areas.

1) Attract

TSH have developed a Recruitment Strategy and Action Plan in June 2022 to meet the organisational objectives of recruiting and retaining an effective and modern workforce. The purpose is to ensure that we recruit the right people, in the right place at the right time. This strategy is not only aimed at attracting new / returning staff but also those who are under schemes developed to provide routes to employment. A Short Life Working Group has been established to update this Strategy with an additional emphasis on retention and marketing TSH as a great place to work. This is due to be approved in June 2023.



In order to develop the organisations profile, actions to widen the reach for potential new employees have been introduced.

These actions include:

- Attendance at job fayres
- Rebranding of the logo / brand for TSH
- Increased use of social media

Further local work is required to analyse positive response rates for roles, where we are attracting candidates from and maximising good practice. For example the table below demonstrates the top ten places where candidates who applied for roles, discovered our adverts

Advert Source	Candidates who applied Count	Advert Source	Candidates who applied Count
Indeed	422	LinkedIn	103
NHS Scotland Website	320	NHS Intranet	91
Candidate did not disclose	281	Google	59
Word of mouth	125	Other	51
NHS Internal Job	112	Facebook	47

Using Social Media within TSH is in its infancy however we will continue to monitor its usage to ensure we are utilising this as widely as possible. Analysis of data has revealed that TSH has run a similar number of recruitment adverts in 22/23 compared to 21/22.

Year	No of Adverts/Campaigns	No of Posts to be Filled
20/21	53	77
21/22	92	164
22/23	89	153

TSH has also prioritised retention of staff within the strategy and will continue to develop this strand of work in 2023/24. Current progress has been the development of the on-boarding process and induction programme for all new employees. All members of staff who have either change roles or are new to the Board will be contacted at three, six and twelve months to check in on their experiences to date.

With regard to leavers, TSH have introduced a process on MS forms that all leavers are asked to complete exit interviews in confidence using an easy to access QR code. This has proven successful where the levels of input has increased and those leaving the organisation making contact to give their feedback.

Anchor Organisation

As an Anchor Organisation TSH aims to be an employer of choice and is reflective of the Community. This will form part of our Recruitment & Retention Action Plan, ensuring that we maximise local opportunities.

This includes consideration of the following:

- Location
- Transport Links
- Links with Schools and HEI to look at opportunities for development of future staffing

2) Train

TSH has a strong focus on staff wellbeing, career development, and adhering to staff governance standards to maintain a skilled and motivated workforce that feels valued and is equipped to deliver high quality services and care. TSH is committed to supporting the training and ongoing development of all staff, and a key component of this plan is the provision of education and learning to help train and develop staff at all stages of their employment.

Nurse Practice Development

The Nurse Practice Development Team lead a number of key projects, working closely with organisational development, learning, training and development and the education and development of nursing staff within TSH. These projects are ongoing from 2022/23 into 2023/24 and include:

- Following recent consultation, embed the new clinical care policy into practice and ensure its alignment with the revised clinical model structure.
- Continue to work with colleagues from NHS Education Scotland to undertake a pathfinding project to explore and develop a framework for the delivery of a sustainable model for the delivery of nursing clinical supervision.
- Development of a peer support network that will consist of both clinical and non-clinical peer support workers throughout the organisation. Since the start of 2023 there have been three separate training sessions delivered, with a total of 18 staff now trained as peer support workers. There is a further training date scheduled for June.
- Development of specialist dementia training skill with delivery to 26 nursing staff and seven multidisciplinary team members over six bespoke sessions, and trained nine nursing staff with palliative care and dementia.
- Review the current nursing induction process (including secondary induction) with the dual aim of streamlining processes whilst also increasing the number of inductions carried out each year
- Work to increase delivery of nursing assessment and care planning.

Corporate Training Plan

TSH delivers on a broad range of training and development activities through the annual Corporate Training Plan. This includes a focus on:

- Core statutory and mandatory training - including training on fire safety, health and safety, infection control, information governance, PMVA, equality diversity and rights, safeguarding, security, suicide awareness and prevention, and workplace first aid.
- Clinical practice - including training on autism, epilepsy, food, fluid and nutrition, intellectual disability, physical health and health improvement, relational approaches to care, Talking Mats, and trauma informed care.
- Leadership and management development - with an emphasis on coaching, leadership skills, management essentials and people management skills.
- Practice development - including training relating to clinical supervision, excellence in care, improving observation practice, key worker development, Flying Start and New to Forensics.
- Psychological Therapies - including training on CBT for psychosis, low intensity psychological therapy, life minus violence therapy, MBT, personality disorder risk assessment, positive behaviour support, trauma & PTSD, violence risk assessment and management, and external supervision for staff delivering psychological therapy programmes.
- Quality Improvement - including training on feedback & complaints, QI essentials and realistic medicine.
- Records management and data protection training – including DPIA training, and training on effective records management and record keeping.
- Risk and resilience - including incident command training, comms officer training, ‘Golden Hour’ training, and multi-agency incident response training.
- Technology and digital skills - including training to support the implementation and rollout of eRostering, and training on key IT systems including Datix, eESS manager and employee self-service, HEPMA, Tableau dashboard and RiO.
- Workplace wellbeing - including training on leadership for mentally healthy workplaces, mental health first aid, psychological safety, and peer support training.

- Whistleblowing - with a focus on ongoing roll-out of the INWO Whistleblowing Standards online training programme.
- Bursary scheme - to support staff undertaking further education.

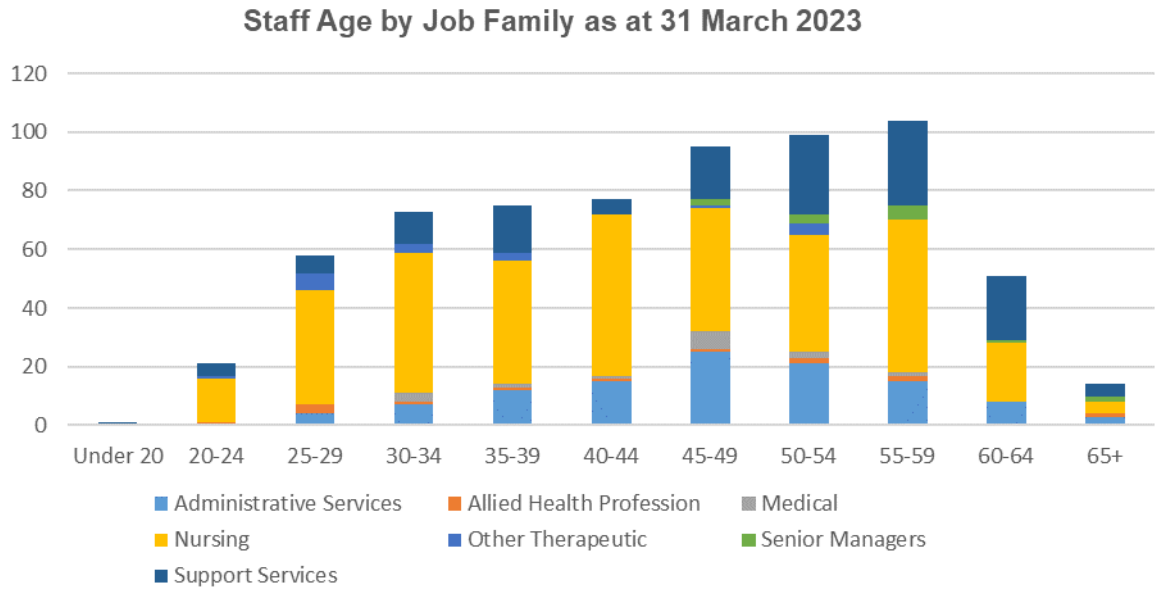
A total of £81,308 has been allocated from the Corporate Training Budget to support delivery of corporate training for 2023/24.

In 2022/23 TSH achieved its targets for both statutory and mandatory training, 94.2% compliance for statutory training and 85.9% compliance for mandatory training against an 80% target. The compliance rates have been progressing in an upwards trajectory since September 2021.

3) Employ

Staff are TSH greatest asset and resource, 84% of TSH budget is committed to staff costs. Delivery of high quality care is dependent on recruiting a workforce who are skilled and retaining their skills to ensure we meet patient care needs.

The chart below demonstrates the age range of TSH employees and associated job families.

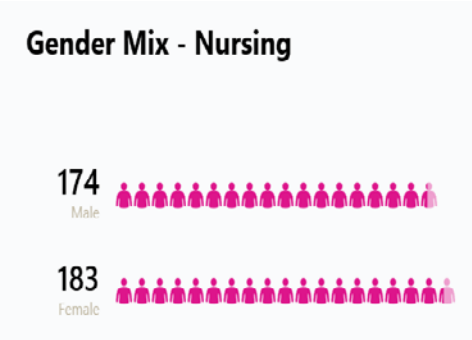


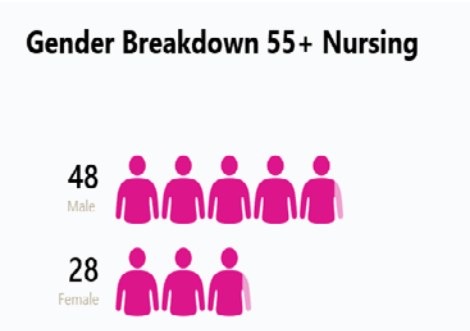
There is a slight reduction in all staff numbers in the 50 to 65+ category by ten and an increase in the age under 20 to 49.

Within the Nursing staff group, we are seeing higher levels of staff returning to join the Supplementary Staffing Register once retiring. The number of 50+ employees has reduced by 14 and we are seeing an increase in staffing under 49.

Gender Mix

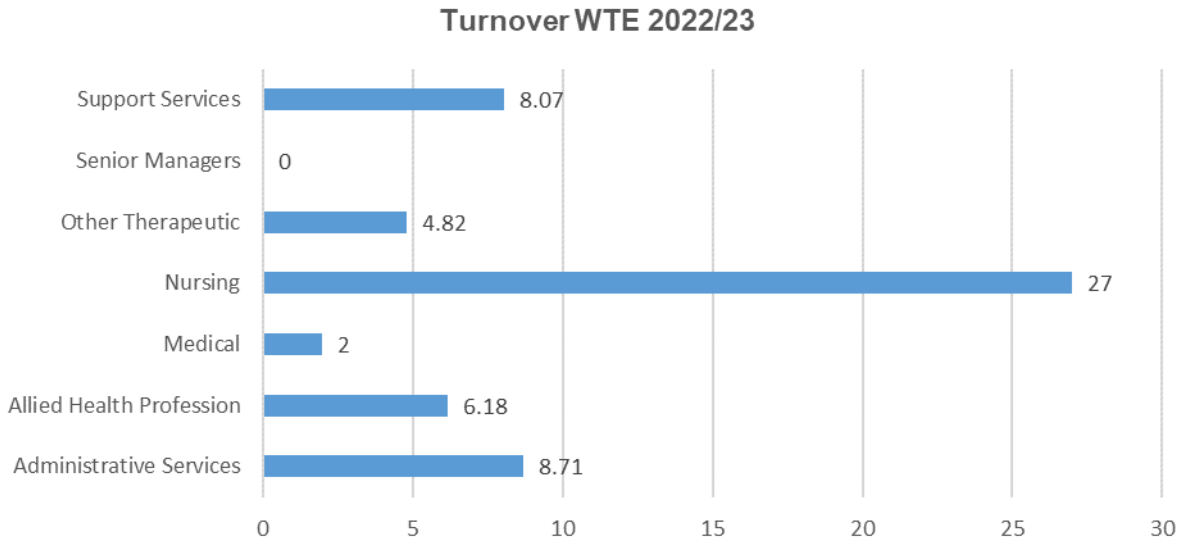
Gender mix in nursing staff is a consideration in resource allocation. Current gender distribution for nursing staff is below for information.





Turnover

Turnover in 2022/23 was 70 staff, 56.78 WTE. For Nursing there was 31 leavers, 27 WTE. Work continues on the area of retention within our updated Recruitment & Retention Strategy.



Recruitment

It is essential that TSH support staff through the employment process. This ensures a welcoming introduction to TSH and provides a consistent and robust process. In 2022/23 a series of KPI's were developed to track the performance of the recruitment process. These are reported monthly to the Workforce Governance Group. TSH also fully embraced Job Train as the platform for recruitment, ensuring that each manager now utilises this platform to fill vacancies.

Key vacancies have been secured in year. TSH has stabilised its infection control resource through the recruitment to the role of the Infection Control Facilitator. This resource will be embedded permanently into organisation's resilience approach. Proactive recruitment has also taken place in roles where there is a known turn over. Challenges continue to exist in filling Nursing Band 5 vacancies and TSH have reviewed skill mix of teams to balance potential shortfalls.

TSH is committed to developing apprenticeship programmes to assist in balancing our ageing workforce and help attract more staff into a career within the NHS. There is one Modern apprentice currently in post in the organisation. There is commitment to providing two modern apprenticeship placements within nursing per year, and opportunities for future expansion of apprenticeship programmes within the organisation will be actively explored.

4) Nurture

TSH is committed to providing a healthy working environment which promotes and protects the physical and mental wellbeing of its employees. A tiered support model has been adopted based on the principles of Psychological First Aid (i.e. Care, Protect, Comfort, Support, Provide, Connect, and Educate).

Our workforce is the most valuable asset and therefore we will continue to ensure that individuals are fully supported in the pivotal roles of maintaining safety and security whilst delivering front line care to patients in sometimes challenging and complex circumstances. A permanent Wellbeing Centre has been in place since October 2020. This provides a space for both Staff and Volunteers to relax and recuperate.

Support offered over 2022/23 includes:

- Programmed targeted information sessions e.g. women and men's health weeks, activity challenges which engaged over 50 staff members, credit union, creative writing and outreach 'Coffee, Cake and Conversation' which engaged 123 staff over 9 events.
- Support for all Staff and Volunteers to access the Wellbeing Centre for specific wellbeing events e.g. workplace massage therapy.
- Direct peer support with 16 staff trained in 2023.
- Pastoral support via Staff Care Specialist, information events, signposting, listening spaces or coaching. Pastoral care have provided support for 56 referrals.
- Provision of targeted interventions linked to existing priority work streams (e.g. trauma informed care and psychological safety) specifically aimed at enhancing line manager capability in relation to Staff wellbeing and support. e.g. 20 managers have been trained in Supporting a Mentally Healthy Workplace

A three-year Staff & Volunteer Wellbeing Strategy and Action Plan has also been developed and approved at the Board in April 2022. This Strategy is for all Staff, Volunteers and any colleagues who work for TSH. The Strategy focuses its efforts in eight areas: mental health, environmental, financial, personal growth and development, physical health, social, spiritual and occupational. It encompasses the work of Healthy Working Lives as well as any wellbeing work across the organisation.

The Strategy and Action Plan will undergo scrutiny through evaluation using local data, set KPI's and feedback from stakeholders.

Over the course of the next three years, implementation will involve ensuring support at the following levels:

- Self-help, providing resources and signposting staff.
- Peer, offering advice and opportunities for staff to access one-to-one or group support.
- Line management, ensuring appropriate training opportunities are available for our managers.
- Organisational, making the links with the relevant organisational and national groups to ensure our approach is inclusive, comprehensive and encompassing.

TSH will continue to encourage feedback through iMatter questionnaires and the completion of Action Plans by each Team. "What Matters to you" was carried out in 2022/23 and will continue to be asked on an annual basis to ascertain what additional supports can be put in place for all staff and volunteers.

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. As part of the Whistleblowing Standard, a quarterly update is provided to the Board on the current situation with any outstanding Whistleblowing Investigations. An Annual Report is also produced and a copy is also sent to the INWO for their information.

Attendance Management

Attendance management continue to be challenge within TSH. The figures below demonstrate an upward trend, with 2022/23 saw an overall increase in our Sickness Absence

Sickness Absence

Nursing Staff

Sickness Absence for Nursing Staff has also increased and work will continue on improving the support to all nursing staff with an overall 2% reduction request during Performance Reviews on a quarterly basis.

Actions for 2023/24 include:

- A Task and Finish Group has been established to develop and action plan to support absence management.
- TSH have engaged a new Occupational Health Service, which will support staff health and on return to work.

4 RECOMMENDATION

The Board are invited to note the information and update.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Workforce Plan links into Financial and Clinical Governance Plans and processes.
Workforce Implications	The Workforce Plan includes implications for workforce in relation to • Demographics - age profiling and potential impact of pension changes on workforce • Recruitment and retention of appropriately skilled workforce and sustainable workforce • Staff support, health and wellbeing
Financial Implications	The Workforce Plan financial impact is consistent with the level of funding contained within the TSH's Financial Plan.
Route to Board Which groups were involved in contributing to the paper and recommendations.	Staff Governance Committee Partnership Forum
Risk Assessment (Outline any significant risks and associated mitigation)	Workforce Planning is included within the Corporate Risk Register and reported on through the Staff Governance Committee and NHS Board on a regular basis.
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.

Health Workforce Directorate
Health and Social Care Workforce Planning and Development Division
Stephen Lea-Ross, Deputy Director

E: DeputyDirectorofHealthWorkforce@gov.scot

a b c d

05/05/23

Dear Colleagues,

THREE YEAR WORKFORCE PLANS: DEVELOPING AN INTEGRATED PROCESS

Purpose

1. This letter highlights recent developments with regard to two practical workforce planning issues.

    - The first issue – requiring your action - is the **review of three year workforce plans** – covered in paragraphs 2-10 below.

    - The second issue – primarily for information at this stage - concerns **quantification of local workforce need**, and is covered at paragraphs 11-13 below.

Review of three year workforce plans

2. Scottish Government guidance to NHS Boards and HSCPs on three year workforce plans was set out on 1 April 2022 in DL 2022 (09) DL(2022)09 - National Health and Social Care Workforce Strategy: Three Year Workforce Plans (scot.nhs.uk)

3. Paragraph 10 of DL 2022 (09) asked NHS Boards and HSCPs:

    - to review and update their workforce plans annually in the years between publication of full three year plans, to reflect progress on actions and workforce planning assumptions; and
    - to submit annual revisions to the Scottish Government WFPPMO@gov.scot, with updated plans published on organisations' websites by the end of October each calendar year.

4. Colleagues in NHS Boards have sought clarification on these requirements, following Scottish Government guidance circulated in February 2023 on Annual and Medium Term Development Plans (ADPs). This guidance includes sections requiring responses from NHS Boards on local workforce planning issues.

5. To streamline reporting, and rather than separately submitting annual workforce plan revisions to the Scottish Government under the DL requirements above, NHS Boards are therefore asked to use the ADP process to update the Scottish Government on their workforce plans and to work with HSCPs to provide comprehensive updates on workforce planning.

6. The Health Workforce Planning and Strategy Unit will consider the ADP sections on workforce planning as part of the overall ADP process, responding as appropriate to NHS Boards and HSCPs on revisions to three year workforce plans.

7. This development is part of an ongoing process to evolve planning arrangements for service, finance and workforce so that they can be considered together within a more effective integrated context.

8. To sum up, we are therefore requesting that:

    - NHS Boards use the ADP process instead of the DL guidance to respond as they undertake the annual review of their workforce plans;
    - HSCPs undertake a collaborative approach, with the NHS Boards in their areas by feeding into their workforce plans.[1]

9. In addition to what is asked within the ADP, we ask that NHS Boards and HSCPs set out in their ADP responses:

    - how they are measuring against their actions set out in their three year workforce plans;
    - what are the main/new and emerging challenges to their workforce and objectives of their three year workforce plans.

10. For the first point, Boards and HSCPs should outline progress toward the actions they advised they would take in their three year workforce plans. For the second point, Boards and HSCPs should advise of the main challenges as well as any unforeseen and emerging challenges they are facing that were not included in their three year workforce plans. We ask that answers to these two points are provided within the workforce section in the ADP which is **due for return 8 June 2023**.

Quantification of workforce supply/demand needs

11. Scottish Government feedback in 2022 to individual Boards on their three year workforce plans identified that further work would be required to accurately quantify levels of anticipated workforce need, particularly given continuing financial challenges. More quantified information will be key to informing future decisions on workforce planning, particularly where that involves investing in workforce capacity where it is most needed.

12. We believe Boards and HSCPs would welcome further support to undertake this quantification more effectively and consistently. We are working in partnership with

[1] The ADP guidance requires Delivery Plans to be developed in a complementary way, with clear reference to IJB Strategic Plans and priorities, including reference to workforce plans; and to demonstrate local partnership working across IJBs and Local Authority Partners, as well as joint deliverables.

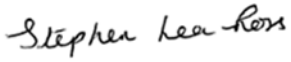
colleagues in NES and the Centre for Workforce Supply to see how supply and demand challenges can be helpfully represented and modelled.

13. Good progress is being made in constructing a modelling tool which can be used both nationally and at local level. Prior to introducing this tool, further discussion, presentation and testing will be required first with regional and national groups with involvement in workforce planning. We are embarking on this process now.

Further guidance

14. As set out in this letter, we are striving toward a more integrated approach to reporting on workforce planning. We are considering this further with colleagues, and will update you in the Summer on future reporting processes.

Yours sincerely



Dr Stephen Lea-Ross
Deputy Director,
Health Workforce Planning and Development

THE STATE HOSPITALS BOARD FOR SCOTLAND
STAFF GOVERNANCE COMMITTEE

Minutes of the meeting of the Staff Governance Committee held on Thursday 16 February 2023

This meeting was conducted virtually by way of MS Teams, and commenced at 9.45am.

Chair:	
Non-Executive Director	Pam Radage
Present:	
Employee Director	Allan Connor
Non-Executive Director	Stuart Currie
Non-Executive Director	Cathy Fallon
In attendance:	
Professional Nurse Advisor	Josie Clark
Chief Executive	Gary Jenkins
Unison Representative	Jacqueline McDade
Director of Workforce	Linda McGovern
Board Chair / Non-Executive Director	Brian Moore
Head of HR	Laura Nisbet
RCN Representative	John Roe
Board Secretary	Margaret Smith
PA to Chair / CEO	David McCafferty ***(Minutes)***

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

Ms Radage welcomed everyone to the meeting, and apologies were noted from Alan Blackwood, POA Representative, Chelsie Burnside Staff Side Representative, Michelle McKinlay Staff Side Representative.

2 CONFLICTS OF INTEREST

There were no conflicts of interest noted.

3 MINUTES OF THE PREVIOUS MEETING HELD ON 17 NOVEMBER 2022

The Committee approved the Minutes of the previous meeting held on 17 November 2022 as an accurate record of the meeting.

The Committee:

1. Approved the minute of the meeting held on 17 November 2022.

Ms Fallon requested any update on wellbeing funding allocation from Scottish Government from the previous minute of meeting 17 November 2022 and Ms McGovern confirmed that there was currently no further update at the present time. It was understood that further information around funding allocations was awaited at a national level and Mr Jenkins confirmed that this item was discussed at the Board Chief Executive meeting on 14th February.

4 MATTERS ARISING: ACTION LIST UPDATES

The Committee noted the rolling action list and Ms Radage confirmed that the rolling actions from the last meeting had either been closed off or were an agenda item for discussion at this meeting.

The Committee:

1. Noted the updated action list.

5 OCCUPATIONAL HEALTH SERVICE PROVISION UPDATE

The Committee received the report which summarised the position on the Service Level Agreement for the provision of Occupational Health and Safety Services. The SLA with SALUS had been extended to 31st March 2023 through agreement by the State Hospital's Board. A tender process was taken forward and two bids were noted to have been received. A Short Life Working Group was set up to consider the two tenders and it was confirmed that the recommendation of the SLWG was to move from SALUS to NHS Dumfries and Galloway as a preferred provider and this incorporated the benefit of a two year package of in-house support and improved costing. This was presented to the TSH Board, who approved this as the way forward.

Ms McGovern advised the Committee that four appointed members of NHS Dumfries and Galloway staff, including three nurses and a physiotherapist, would attend for hospital inductions from 6th March to allow for the opportunity to meet with staff and that the team would be based in the Wellbeing Centre within the Harris Building. Introductory sessions would be arranged and a communication to all staff would be produced notifying staff of the finer details of the change to the service provision and with an opportunity for staff to provide feedback. Ms McGovern would arrange for the team members to attend a future meeting of the Committee to allow the opportunity for introductions.

ACTION: L MCGOVERN

Mr Currie commented that it was important to focus on both quality of service as well as value for money, and that it would be crucial to monitor the impact of this change of service especially on sickness absence.
Ms Radage noted that a Short Life Working Group subset would continue to monitor the progress of this new arrangement on a quarterly basis allowing for scrutiny and adaption if required, and this was welcomed by members. Mr Moore also welcomed the fundamental difference of now having a nurse-led service which was noted to also have been implemented successfully elsewhere within NHS Scotland.

The Committee:

1. Noted the Service Level Agreement for the Provision of Occupational Health and Safety Services.

6 WORKFORCE REPORT

The Committee received the report as summarised by Ms McGovern, Director of Workforce. The report provided an update on overall workforce performance to 31st January 2023.

Detail was provided around attendance management figures for staff overall as well as separate figures pertaining to nursing staff. 59 staff were noted to currently being managed through the formal stages of the Attendance Policy which was reported as an increase and the importance of staff being supported by managers through the process was highlighted. Main reasons for long term absence included unknown causes and work continued with managers to help ensure a reason was included for absence allowing for a robust package of support to be provided for both staff remaining at work and being supported back to work. Funding was noted to be available

from the Scottish Government for a further 12 months for the continuation of the Business Disability Forum consultancy service to help assist staff with reasonable adjustments when returning back to work. Two sessions in February and March would be run for managers which would produce a guide in partnership around legal obligations and best practice.

Work was being done to reduce recruitment KPI timelines including to encourage managers to provide shortlist and interview dates for advertised posts. Participation at Queen Margaret University (QMU) recruitment fayre on 1st February and planned participation at Royal College of Nursing Recruitment Fayre on 21st February was noted along with a planned recruitment drive at the National Conference in June and July. Ms McGovern noted an initial lack of communication from the University in relation to the QMU recruitment fayre but further advised that two applications had been received.

In relation to turnover, 76 staff had left the organisation within financial year 2022/23. Work was ongoing with exit questionnaires and provision of QR codes for staff to access questionnaires. Paper would be produced in collaboration with a Short Life Working Group around suggestions and ideas on the retention of staff.

PDPR compliance numbers were now being included along with percentages and the committee agreed this addition was helpful in establishing a more accurate picture of compliance.

Mr Connor noted the non-compliance rates for completion of PDPR, and the need for improvement in this areas. He also raised the question around what work was being done to address high absence rate figures and further highlighted EASY compliance figure for January was 59% and that completion of Return to Work documentation was too low.

Ms McGovern advised that work underway to address these questions included regular communication at Occupational Health meetings with the focus on long and short-term absence alongside discussions with Senior Charge Nurses on how to communicate these issues to staff and a proposal for a more person-centred approach to offer staff interventions in relation to EASY compliance. She noted that Stage 1 & 2 figures had been picked up by the team with a focus on developing the skills of managers on how to guide staff through each stage. Ms Nisbet added that a new role had been developed within the HR department to take particular focus on this areas.

Mr Currie noted that PDPR compliance was particularly important as it provided an opportunity to open a conversation with staff and link to how they felt about working for the organisation more widely. In terms of absence, he noted that once covid absence was removed, the levels of sickness absence were not sustainable.

Mr Jenkins noted absence had been picked up at Directorate Performance Review meetings in January 2023, and explained that an increased target of 2% month on month had been set. He felt it was important to allow the management teams to take action and improve the position, but added that a Task and Finish Group would be considered if there was not significant improvement made. He also placed this within a national context of sickness absence having increased across NHS Scotland as a whole. PDPR compliance would also feature as part of the Performance Review meetings to help move this forward.

Ms Radage summed up for the Committee, noting the reporting provided good data across workforce issues. She added that it was important for managers to understand that PDPR compliance was an intrinsic part of their roles. In terms of sickness absence , it would be helpful to compare to other high secure hospitals in the UK. Further, that sickness absence performance should be evaluated towards the end of the year following implementation of the new Occupational Health arrangements to see what differences and impacts the change had made.

ACTION: L MCGOVERN

<u>The Committee:</u>

1. Noted the Workforce Report.

2. Agreed to take action as recorded above in terms of absence rate comparisons towards the end of 2023 following implementation of the new Occupational Health arrangements.

7 WORKFORCE GOVERNANCE REPORT

The Committee received the Workforce Governance Group Report and Mrs McGovern provided members with a summary of the content and the included Terms of Reference document. The second meeting of the Workforce Governance Group had taken place and it was noted that the group would form part of the existing organisational structure but with a remit for workforce governance and as there was a need to consider the wider requirements from a workforce governance perspective, help to support the organisation to deliver the TSH workforce plan and meet the various workforce governance policies. The group would approve all workforce requests with the outcome being fed back to CMT for final approval. A Nursing, AHP and Psychology subgroup was noted to report into the Workforce Governance Group on a monthly basis allowing for a response to emerging issues. Regular update on the actions from the Workforce Governance Group would be reported to the Staff Governance Committee on a regular basis.

Mr Jenkins welcomed the work of the group which provided a process which was followed, would be overseen, governed and provide transparency. Ms McGovern noted that the process would build trust and provide assurances to the Board in relation to the recruitment process and allow for recommendations to be made in relation to funding. Ms Radage welcomed this, noting that it should help to drive efficiency and demonstrate transparency.

<u>The Committee:</u>

1. Noted the Workforce Governance Report.

8 STAFF AND VOLUNTEER WELLBEING REPORT – QUARTER 3

Committee members received and noted the Staff and Volunteer Wellbeing Report as presented by Ms McGovern. The report provided an update on progress of the strategy and associated action plan. Highlights included Self-help initiatives which provided access to resources for staff including Credit Union Services and Coffee, Cake and Conversation sessions providing staff with an opportunity to relay wellbeing feedback. Peer support initiatives included wellbeing team check-ins and peer support network training. Line management initiative included ongoing mentally healthy workforce sessions for managers. Organisation initiatives included a memorial garden for staff and patients – work was underway in relation to costing for this.

Footfall figures for the Wellbeing Centre for January 2023 were at 335 and this was an increase from 272 in October 2022.

Mr Currie noted that there was a range of good initiatives in the report and that it was particularly positive to see the work around the credit union as well as peer support initiatives. He also noted that it may be helpful to link in with former employees to gain their insights, if possible.

Ms Fallon asked if more information could be provided re the trial piloted with Lewis 3 in terms of access to wellbeing services. She added that it would be helpful if each of the KPIs could be noted within reporting so that it was clear what was being reported on in each instance.

Actions – Linda McGovern

Ms Clark noted the importance of having information made available to staff in relation to wellbeing placed on the new hospital website.

Mr Connor noted that the Wellbeing Centre was a valuable resource with increasing numbers of staff reporting a gained benefit from it. Solutions in relation to ward staff accessing the service due

to shift working patterns were noted to be complex, however positive feedback from a Staff Side perspective was noted.

Ms Radage noted that the range of services on offer was positive with encouraging increased footfall figures and financial wellbeing as part of the discussion and it was hoped this would have a positive impact on absence rates later in the year.

Mr Jenkins noted the resource figures in relation to staffing and budget, and was in agreement that this service was a priority and would continue to be supported. Mr Currie added to this that it would be essential to ensure that those initiatives that could be demonstrated to be the most impactive and beneficial could be taken forward.

On behalf of the Committee, Ms Radage noted that this report should continue to come to the committee and as the year progressed, it would help to demonstrate the benefit of the range of initiatives on staff and volunteer wellbeing. This aspect, in terms of the difference being made, should be highlighted in reporting throughout the remainder of the year.

Action – Ms McGovern

The Committee:

1. Noted the Staff and Volunteer Wellbeing Report – Quarter 3.

2. Asked for changes to be made to reporting as outlined herein.

9 iMATTER - UPDATE

Members received and noted the iMatter update report and the content was summarised by Ms McGovern. The 2022 iMatter questionnaire was issued on 23 May 2022 and response rate figures showed an increase of 3% from last year. Areas of challenge including the five lowest scoring areas were discussed and included Board members not being sufficiently visible, ensuring opportunities for staff involvement in organisational decision-making, and a continued focus on supporting the wellbeing agenda across the organisation. The iMatter cycle would commence in May 2023 with additional whistleblowing questions included. A new IT system was noted to be in development and would be launched in time for the 2024 cycle.

There was discussion on what the question raising the visibility of Board members actually meant, and how well this was understood across staff groups. Ms Fallon noted that, it would be important to understand what staff members were requesting in response to this, and how to show staff what the Board does other that set activities such as leadership walk rounds.

Mr Moore offered the view that visibility had improved over the last 12 months with Board members attending PPG meetings and regular leadership walk rounds and that it was important to continue participating in these sessions, however, he also thought it would be beneficial to staff how the Board operated and took decisions, as well as to communicate further on the work of the governance committees through staff bulletins.

Ms Smith noted that Non-executive Director engagement could be most impactful if it was through meaningful engagement with staff and patients that opportunities to do this were already being undertaken through the PPG and leadership walkrounds. Education of staff in relation to how the Board functions and incorporating this into development of managers who have an organisational focus was an option to explore including the role of the Board. Mr Jenkins added that this was the type of approach being taken across directorates in relation to developing key strategic planning such as the Annual Operating Plan to make sure staff were both aware and engaged.

Ms McGovern noted that the Director of Nursing and Operations had commenced an on-floor shift within the ward area and feedback was awaited in relation to this.

The Committee:

1. Noted the content of the iMatter report.

10 WHISTLEBLOWING REPORTS

a) Quarter 3 Update

The Committee received and noted the Quarter 3 Update report for 1st October 2022 to 31st December 2022 and the content was presented by Ms McGovern. There were no formal Whistleblowing cases raised within the State Hospital Board during this quarter. Reference was made to an anonymous whistleblowing concern made directly to the Independent National Whsitleblowing Office, however the Independent National Whistleblowing Office confirmed that this was for awareness only and no action was required subject to this and this would not be pursued. The State Hospital was noted to have participated in the 'Speak Up Week' and positive feedback had been received in relation to this. Appointment of the Non-executive Whistleblowing Champion Shalinay Raghavan was noted by members.

The Committee

1. Noted the content of the Quarter 3 Update.

b) Annual Report

The Committee received the draft Whistleblowing Annual Report for 1 April 2022 – 31 March 2023. Ms McGovern advised members that this was a draft at present and that Committee members contact her with any feedback for inclusion in the report.

Mr Moore clarified that the Annual Report was requested as a standard for the financial year. Separately, a Whistleblowing champion response letter was provided to the Cabinet Secretary providing assurance in relation to reporting arrangements. As the State Hospital had only just filled this vacancy, Mr Moore would undertake to provide this assurance letter, and it was confirmed that this would be added to the Board agenda for the meeting taking place this month.

The Committee:

1. Noted the content of the Draft Whistleblowing Annual report, and the report for Quarter 3.

11 CORPORATE RISK REGISTER – HR RISK SPECIFIC

Members received the Corporate Risk Register report specific to Workforce Risks. Three specific HR related risks were identified within the report one rated as high, one rated as medium and one rated as low risk. The high risk relating to a deliberate leak of information to the media was being reviewed on a monthly basis and resources had been developed to allow staff options on how to deal with concerns, including concerns of patients. The medium risk was noted to be in relation to the development of the Workforce Plan and that this would be reviewed in April with issues being addressed by the Workforce Governance Group. The low risk was in relation to compliance with Mandatory PMVA Level 2 Refresher Training and work continued to ensure the programme remained high on the agenda for staff and managers.

Ms Radage asked for clarity on what further action could be taken in relation to HRD111. Mr Jenkins noted that this had been discussed at the last meeting of the Audit Committee and in particular the deliberate leak of information to media.

The Committee:

1. Noted the content of the report.

12 COMMITTEE SELF-ASSESSMENT

The Committee received the Committee Self-Assessment paper and the content pertaining to this was presented by Ms Smith. The paper set out the results of a self-assessment survey which took place in November 2022 to rate the Committee's performance in five areas - Setting the Direction, Holding to Account, Assessing the Risk, Engaging Stakeholders and Influencing Culture and that this followed the blueprint for good governance. Twelve responses were noted and feedback was generally positive in each area. Negative points to highlight were discussed including in relation to staff governance standards and how those were best taken forward. Assessing risk was noted to have been actioned at an RSM risk event in December. The final point discussed was how the Committee communicated priorities to staff.

Mr Currie commented that it would be interesting to see how this developed over time, and also that it would be helpful to sense check with wider staff groups as to how credible and meaningful they saw the Committee's role to be.

Mr Moore noted that it would be helpful to consider how the Committee can bring out the staff governance standards more clearly perhaps through the structure of the agenda itself. This may help going forwards, especially how to make discussion more future and direction focused. Mr Jenkins commented that organisational Corporate Objectives could be applied to the governance standards as a means of an evidenced framework.

Ms Radage clarified that this process would be repeated annually, and summed up for the Committee be noting the usefulness of the assessment and today's discussion and suggestions.

The Committee:

1. Noted the content of the report.

13 PARTNERSHIP FORUM MINUTES DATED DECEMBER 2022

The Committee received minutes from the last Partnership Forum dated December 2022 to note. Ms Fallon raised the question in relation to whether the action plans from Staff and Clinical Governance Committee meetings could be shared with Partnership Forum as a means of sharing information and also raised the question in relation to information on Public Health Scotland's replacement for Healthy Working Lives Awards. Ms McGovern advised that further information was awaited in relation to this and that the suggestion was to move forward with the action plan until further information was provided from Public Health Scotland.

Mr Jenkins picked up on the question of feeding in Committee Action Plans to Partnership Forum and noted that he would discuss this along with the Co-Chair of the Partnership Forum to establish an opinion on whether this would be beneficial.

ACTION: G JENKINS

The Committee:

1. Noted the content of the Partnership Forum Minutes dated December 2022.

14 UPDATE REPORT FROM HR AND WELLBEING GROUP

Members received the update report from the HR & Wellbeing Group for noting. Ms McGovern added that the HR & Wellbeing Group reported through Staff Governance Committee via Partnership Forum and CMT and that the report provided oversight into the items and matters

which were being discussed. Staff members from Occupational Health team would provide an introduction session at the next meeting of the HR & Wellbeing Group in March alongside a presentation in relation to the implementation of a staff self-help support service.

The Committee:

1. Noted the content of the report.

15 ANY OTHER BUSINESS

Ms Smith noted that at the last Clinical Governance Committee meeting, there had been agreement to add a standing item which would allow for read-across of any issues which were raised at one committee and may be of relevant interest to another. The Committee approved this suggestion and Ms Smith would add this particular item to the agendas going forwards.

ACTION: M SMITH

16 DATE AND TIME OF NEXT MEETING

The next meeting will take place on **Thursday 18 May 2023 at 9.45am via MS Teams**.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 June 2023
Agenda Reference:	Item No: 22
Sponsoring Director:	Director of Finance and eHealth
Author:	Director of Finance and eHealth
Title of Report:	Audit Committee – Annual Report 2022/23
Purpose of Report:	For Decision

1 SITUATION

The Report outlined in Appendix 1 is presented to the committee to meet the requirements within the Committee's Terms of Reference to submit an annual report of the work of the Committee to the Board. The report also supports the Governance Statement in providing periodic reports to the Board from the Committee in respect of Internal Control.

2 BACKGROUND

The establishment of an Annual Report by the Audit Committee is an important assurance process to the Board in considering the effectiveness of internal controls.

The report outlines the work of the Committee, including:

- Frequency of meetings
- The activities of the Committee
- Progress in Corporate Governance
- Update Terms of Reference

An effective system of internal control is fundamental to securing sound financial management of the Board's affairs.

The consideration and review of internal and external audit reports, and management responses, together with reports submitted by other officers, assist the Committee in advising the Board with regard to material risks.

3 ASSESSMENT

This report is presented in draft for approval to present to this afternoon's Board Meeting.

4 RECOMMENDATION

The Board is asked to approve the Audit Committee Annual Report for 2022/23.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Year end reporting to demonstrate that the committee has met its remit
Workforce Implications	None identified as part of reporting
Financial Implications	None identified as part of reporting
Route To Audit Committee Which groups were involved in contributing to the paper and recommendations	Submitted for the approval of the committee prior to being submitted to the Board
Risk Assessment (Outline any significant risks and associated mitigation)	None identified
Assessment of Impact on Stakeholder Experience	No impact identified
Equality Impact Assessment	Nor required
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	No impacts identified
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One ✓ There are no privacy implications. ☐ There are privacy implications, but full DPIA not needed ☐ There are privacy implications, full DPIA included

THE STATE HOSPITALS BOARD FOR SCOTLAND

AUDIT and RISK COMMITTEE ANNUAL REPORT

1 April 2022 – 31 March 2023

1 INTRODUCTION

The Report is submitted to meet the requirements within the Audit and Risk Committee's (the Committee's) Terms of Reference to submit an annual report of the work of the Committee. The report also seeks to satisfy the Governance Statement requirement for the Committee to provide periodic reports to the Board in respect of Internal Control.

At the meeting on 6 April 2023, the Committee reviewed its terms of reference, to formally take the title of Audit and Risk Committee.

2 MEMBERSHIP AND ROLE OF THE COMMITTEE

Audit and Risk Committee

Membership

D McConnell
A Connor
P Radage
S Currie

Role

To oversee arrangements for external and internal audit of the Board's financial and management systems and to advise the Board on the strategic processes for risk, control & governance. It met four times during 2022/23 taking into account that the timing of the final meeting was moved to 6 April 2023.

Committee Member	No. of meetings
David McConnell	4
Allan Connor	4
Stuart Currie	3
Pam Radage	4

**including meeting re-scheduled to 6 April 2023*

3 AUDIT

External audit coverage of the Board was provided by KPMG.

The Internal Audit service was provided by RSM UK.

4 REVIEW OF THE WORK OF THE COMMITTEE

The Internal Audit Operational Plan from RSM for 22/23 was approved by the Committee at its meeting on 17 March 2022. The plan was kept under review for the remainder of the year.

The plan was designed to target priority issues and structures to allow the Chief Internal Auditor to provide an opinion on the adequacy and effectiveness of internal controls to the Committee, the Chief Executive (as Accountable Officer) and the External Auditors.

During financial year 2022/23, the Committee met on three occasions: 23 June 2022, 29 September 2022 and 26 January 2023. A fourth meeting scheduled for March 2023 was re-scheduled to 6 April, and this meeting was also focused on the 2022/23 year.

During the period from 31 March 2021 and up to the consideration of the Annual Financial

Statements on 22 June 2023, the committee has:

- Received progress reports from the Chief Internal Auditors against the Internal Audit Plans approved by the Committee
- Reviewed audit reports and action plans
- Reviewed progress on action taken by management on action plans
- Reviewed the final Annual Report for 2022/23 from the Chief Internal Auditor
- Received the Annual Report and audit certificate for the 2022/23 audit from KPMG
- Reviewed the Standing Financial Instructions, Standing Orders and Scheme of Delegation, and recommended these for approval to the Board
- Reviewed its Terms of Reference
- Review the log of waivers of standing financial instructions.
- Considered the Fraud Incident Log
- Reviewed Counter Fraud Service Alerts
- Reviewed Fraud Action Plan
- Reviewed progress made with the National Fraud Initiative
- Received national Audit Scotland reports and performance audit studies, relating to the Health Service and to the wider public sector
- Met in private with Internal and External Auditors
- Reviewed the recommendations received from National Services Scotland from their service audit reports.
- Reviewed the recommendations received from NHS Ayrshire & Arran from the service audit report on the National Single Instance (NSI) system
- Reviewed the annual reports from the Governance Committees
- Reviewed the Code of Conduct
- Reviewed and approved the Annual Audit Committee Assurance Statement to the Board
- Reviewed the summary of Losses and Special Payments
- Reviewed and approved the Losses and Special Payment Policy
- Reviewed and approved the Patients Funds Annual Accounts for submission to the Board
- Reviewed and recommended approval of the statutory Annual Accounts to the Board
- Submitted minutes of meetings to the Board throughout the year
- Reviewed external Audit Plan
- Reviewed and noted update on Business Continuity Resilience arrangements
- Reviewed the annual report on Risk and Resilience
- Reviewed and noted the Procurement Annual Report
- Reviewed and noted the Corporate Risk Register
- Review and agreed Audit Committee Work Plan 2023
- Received an update from the Risk, Finance and eHealth Group
- Received an update from the Security, Resilience, Health and Safety Oversight Group
- Reviewed Category 1 and 2 Annual Update on Outstanding Actions
- Received the Annual Update on State Hospital Resilience Arrangements
- Reviewed the Effectiveness of Audit Committee

5 CORPORATE GOVERNANCE

During 2022/23 the Board's Internal Auditors reported on the following significant areas of work:

- Key Financial Controls
- Workforce Planning and Rostering
- Incident Management
- Performance Management
- Payroll
- Action Tracking

Implementation of New Clinical Model; Resilience of Security Systems audits were moved to 2023/24 reporting period.

6 CONCLUSION

Based on the work that it has undertaken the Committee has met in line with the Terms of Reference, has fulfilled its remit and is satisfied that internal controls are adequate to ensure that the Board can achieve the policies, aims and objectives set by Scottish Ministers, to safeguard public funds and assets available to the Board, and to manage resources efficiently, effectively and economically.

I offer my thanks for the continuing support and encouragement of Committee members and also to those members of staff who have worked on the Committee's behalf during 2022/23**.**

David McConnell
AUDIT COMMITTEE CHAIR
On behalf of the State Hospitals Board for Scotland Audit Committee

THE STATE HOSPITALS BOARD FOR SCOTLAND
AUDIT AND RISK COMMITTEE

TERMS OF REFERENCE

1 PURPOSE

The Audit and Risk Committee is a standing committee of the Board and shall be accountable to the Board. Its purpose is to provide the Board with assurance in respect of risk, governance and internal control including financial control.

2 COMPOSITION

2.5 Membership

The Committee is appointed by the Board and shall be composed of at least three Non-executive Board members.

Membership will be reviewed annually and disclosed in the Annual Report.

2.2 Appointment of Chairperson

The Chair of the Committee will be a Non-Executive Director, appointed by the Board.
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2.3 Attendance

Executive Directors of the Board are not eligible for membership of the Committee. The Accountable Officer (Chief Executive), Director of Finance and eHealth, Chief Internal Auditor, a representative from External Audit and any other appropriate officials shall normally attend meetings and receive all relevant papers. Other Directors may also be invited by the Chair of the Committee to attend meetings as required.

All Board Members will have the right to attend meetings and have access to all papers, except where the committee resolves otherwise.

Audit Committee members must regularly attend the Committee. This will be monitored and attendance will be reported to the Board annually.

3 MEETINGS

3.1 Frequency

The Audit Committee will meet at least four times a year to fulfil its remit and shall report to the Board at least twice in each financial year.

The Chair of the Committee may convene additional meetings as necessary.

The accountable officer should attend all meetings but if he/she does not, be provided with a record of the discussions.

The Accountable Officer of the Board may ask the Chair of the Committee to convene further meetings to discuss particular issues on which they want the Committee's advice.

3.2 Agenda and Papers

The agenda and supporting papers will be sent out at least three clear working days in advance of the meetings to allow time for members' due consideration of issues. All papers will clearly state the agenda reference, the author and the purpose of the paper, together with the action to be taken.

3.3 Quorum

Two members of the Committee will constitute a quorum.

3.4 Minutes

Formal minutes will be kept of the proceedings and submitted for approval at the next Audit Committee meeting. In line with Board Standing Orders, the Committee should approve the minutes prior to submission of these to the Board.

4 OTHER

In order to fulfil its remit, the Committee may obtain whatever professional advice it requires and invite, if necessary, external experts and relevant members of hospital staff to attend meetings.

If necessary, meetings of the Committee shall be convened and attended exclusively by members of the Committee and / or the External Auditor or Internal Auditor. It is expected that this should occur at least once in each financial year.

The Chief Internal Auditor and the representative(s) of External Audit will have free and confidential access to the Chair of the Committee.

The Chair of the Audit Committee should be available at the Board's Annual Accounts Approval Meeting to answer questions about its work.

5 REMIT

5.1 Objectives

The main objectives of the Committee are to provide the Board with the assurance that the State Hospital acts within the law, regulations and code of conduct applicable to it, and that an effective system of internal control is maintained.

The committee periodically assesses its own effectiveness to ensure that the Committee fulfils its remit, this may involve assessing the attendance and performance of each member.
New members receive a suitable induction and declare his/ her business interests.

The duties of the Audit Committee are in accordance with the Audit Committee Handbook, July 2008. http://www.scotland.gov.uk/Publications/2008/08/08140346/

5.2 Internal Control and Corporate Governance.

5.2 .1To evaluate the framework of internal control and corporate governance comprising the following components:

- **Control environment; Risk management strategy, procedures and risk register;**
- **The effectiveness of the internal control and risk managements systems**
- **Decision-making processes;**
- **Receive and consider stewardships reports in key business areas.**
- **Information;**
- **Monitoring and corrective action**

5.2.2 To review the system of internal financial control which includes:

The safeguarding of assets against unauthorised use and disposition;

- **Maintenance of proper accounting records and**
- **the reliability of financial information used within the organisation or for publication.**

5.2.3 To have a mechanism to keep it aware of topical legal and regulatory issues and ensure the Board's activities are within the law and regulations governing the NHS.

5.2.4 To monitor performance and best value by reviewing the economy, efficiency and effectiveness of operations.

5.2.5 To present an annual assurance statement on the above to the Board to support the Directors' Governance Statement on Internal Control.

5.2.6 To take account of the implications of publications detailing best audit practice.

5.2.7 To take account of recommendations contained in the relevant reports of the Auditor General and the Scottish Parliament.

5.2.8 To review audit reports and management action plans in relation to physical security of the Hospital.

5.2.9 To provide assurance to the Board that plans are in place to ensure service continuity and to provide contingencies for emergency situations.

5.2.10 To provide assurance to the Board that plans and mechanisms are in place to ensure that Fraud is properly monitored and reported.

5.3 Internal Audit

5.3.1 **To review and approve the Internal Audit Annual Plan.**

5.3.2 **To review the adequacy of internal audit staffing and other resources.**

5.3.3 **To monitor audit progress and review audit reports.**

5.3.4 **To monitor the management action taken in response to the audit recommendations through an agreed follow-up mechanism.**

5.3.5 **To consider the Chief Internal Auditor's annual report and assurance statement.**

5.3.6 **To review the operational effectiveness of Internal Audit by considering the audit standards, resources, staffing, technical competency and performance measures.**

5.3.7 **To review the terms of reference and appointment of the Internal Auditors.**

5.4 External Audit

5.4.1 **To review the Audit Plan, including the Performance Audit Programme.**

5.4.2 **To consider all statutory audit material, in particular:**

- **Audit Reports (including Performance Audit Studies);**
- **Annual Reports;**
- **Management Letters.**

5.4.3 **To monitor management action taken in response to all External Audit recommendations including Performance Audit Studies (following consideration by the Staff Governance Committee or Clinical Governance Committee where appropriate).**

5.4.4 **To review the extent of co-operation between External and Internal Audit.**

5.4.5 **Annually appraise the performance of the External Auditors.**

5.4.6 **To note the appointment and remuneration of External Auditors and to examine any reason for the resignation or dismissal of the Auditors.**

5.5 Standing Orders and Standing Financial Instructions

5.5.1 To review changes to the Standing Orders and Standing Financial Instructions.

5.5.2 To examine the circumstances associated with each occasion when Standing Orders are waived or suspended.

5.5.3 To review the Scheme of Delegation.

5.6 Annual Accounts

5.6.1 To review annually (and approve) the suitability of accounting policies and treatments.

5.6.2 To review schedule of losses and compensation payments.

5.6.3 Review the reasonableness of accounting estimates.

5.6.4 Review the external auditors management letter.

5.6.5 To review and recommend approval to the Board of the Annual Accounts.

5.6.6 To report in the Directors Report on the roles and responsibilities of the Audit Committee and actions taken to discharge those.

5.6.7 To review and recommend approval to the Board of the Patients Funds Annual Accounts.

6 AUTHORITY

The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

7 PERFORMANCE OF THE COMMITTEE

The Committee shall review its own performance, effectiveness, including its running costs, and terms of reference on an annual basis.

The committee shall provide guidelines and/ or pro forma concerning the format and content of the papers to be presented.

The Chair of the Committee shall submit an Annual Report on the work of the Committee to the Board.

Subject to annual review
Last reviewed 6 April 2023

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 June 2023
Agenda Reference:	Item No. 23
Sponsoring Director:	Finance & eHealth Director
Author(s):	Finance & eHealth Director
Title of Report:	Patients' Funds Accounts
Purpose of Report:	For approval

1 SITUATION

The Board is required to approve the Patients' Funds Annual Accounts.

2 BACKGROUND

Patients' funds are the balances of money held by TSH on behalf of patients. The Board's Patients' Funds Annual Accounts are presented in a format directed by the Scottish Government Health & Social Care Directorate (SGHSCD) and require to be audited by external auditors, approved by the Audit Committee and authorised by the Chief Executive and Finance & eHealth Director. The 31 March 2023 audit is now complete and the accounts are presented to this meeting for approval.

3 ASSESSMENT

The accounts generally show unpredictable fluctuations in average funds held – simply due to the level of patients' spending and income being fairly inconsistent from one year to the next. The average balance held per patient therefore also fluctuates, with a second consecutive year of a net outflow of funds at a similar level. It should also be noted that an outward transfer was requested pre-March 2022 which would have reduced that inflow by approx. 50% but due to the nature of the transfer it was not able to be transacted until May 2022 – in part contributing to the net outflow in 2022/23.

	March 2022	March 2022	March 2021	March 2020	March 2019
Opening Balance	£677,098	£568,095	£432,617	£459,476	£457,690
Receipts	£614,305	£559,727	£513,243	£441,804	£418,054
Payments	£621,212	£450,724	£377,765	£468,663	£416,268
Net in/(out)flow of funds	£(6,907)	£109,003	£135,478	£(26,859)	£1,786
Closing Balance	£670,191	£677,098	£568,095	£432,617	£459,476
No. of patients at 31 March	109	113	114	113	110
Average funds per patient	£6,148.54	£5,992.02	£4,983.29	£3,828.47	£4,177.05

The Patients' Funds Accounts are audited by Wylie and Bisset who have issued an unqualified audit opinion.

4 RECOMMENDATION

The Board is asked to **approve** the abstract of receipts and payments of Patients' Private Funds for the year ended 31 March 2023 for signature.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives?	Annual accounts require to be presented to the Board for approval.
Workforce Implications	None
Financial Implications	None
Route to the Board (Committee) Which groups were involved in contributing to the paper and recommendations?	Paper prepared by Finance & eHealth Director; reviewed and approved by Audit Committee
Risk Assessment (Outline any significant risks and associated mitigation)	No significant risks identified
Assessment of Impact on Stakeholder Experience	None identified
Equality Impact Assessment	No identified implications
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	No identified implications
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One √ There are no privacy implications. □ There are privacy implications, but full DPIA not needed □ There are privacy implications, full DPIA included.

STATE HOSPITAL **SFR 19.0**

PATIENTS PRIVATE FUNDS

FOR YEAR ENDED 31 MARCH 2023

ABSTRACT OF RECEIPTS AND PAYMENTS

2022 £		2023 £
	RECEIPTS	
	Opening Balances:	
560,135	Cash in Bank	671,106
6,000	Cash on Hand	4,092
1,900	Other Funds	1,900
568,035		677,098
559,667	From or on behalf of Patients	611,023
120	Interest on Patients' Fund Account	3,283
0		
1,127,822	**Total Receipts**	**1,291,403**
	PAYMENTS	
450,724	To or on behalf of Patients	621,212
	Extra Comforts etc.	
	Closing Balances:	
671,106	Cash in Bank	665,066
4,092	Cash on Hand	3,225
1,900	Other Funds	1,900
677,098		**670,191**
1,127,822	**Total Payments**	**1,291,403**
	Closing Balances accounted for as:	
	Patients' Personal Accounts	
677,098	Credit Balances	670,191
-	Less: Debit Balances	-
677,098		670,191
-	Interest Received but not Credited	
677,098	**Total Closing Balance**	**670,191**

I certify that the above abstract of Receipts and Payments is correct, and in accordance with the Books of Account and that the Register of Valuables has been inspected and checked with property held.

Director of Finance & eHealth _____ Date _____

The abstract of Receipts and Payments was submitted at the Board Meeting on 22nd of June 2023 and duly approved.

Chief Executive _____ Date _____

1. Note to SFR19

The Scottish Government Health Directorate requires The State Hospitals Board for Scotland to pre
on an annual basis, an abstract of receipts and payments of patients' private funds administered by
Board. The abstract of receipts and payments of the patients' private funds has been prepared by t
Board, on a cash basis, in accordance with the requirements of the 2022/23 NHS Board Accounts
Manual.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 June 2023
Agenda Reference:	Item No: 24
Sponsoring Director:	Finance and eHealth Director
Author(s):	Deputy Director of Finance
Title of Report:	Financial Position as at 31 May 2023
Purpose of Report:	For Noting

1 SITUATION

This report provides information on the financial performance, which is also issued monthly to Scottish Government (SG) along with the statutory financial reporting template.

The Board is asked to note the Revenue and Capital Resource outturn and spending plans.

2 BACKGROUND

As for 2022/23, an Annual Operating Plan will be submitted for 2023/24, for which reporting was submitted mid March with final submission post-year-end.

Any remaining residual Covid-related costs are now recognised through specific directorates under "business as usual" and will continue in this manner with due recognition of the resultant pressures from any additional posts therefrom.

The draft May accounts show an overspend to date of £0.123m, which is within forecast trajectory at this stage of quarter 1. At the time of this report, the annual accounts external audit is progressing, which is the main focus for the Finance team through April and May.

The delays in the Perimeter Project which are being monitored by the Project Board and are reported elsewhere to the Board - any delay costs are reviewed and quantified for consideration.

3 ASSESSMENT

3.1 Revenue Resource Limit Outturn

The annual budget of £42.881m is primarily the forecast Scottish Government Revenue Resource Limit core and non-core allocations, and additional allocations as anticipated on a recurring basis.

The Board is reporting an over spend of £0.123m to May 2023.

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 regarding our high levels of overtime and high nursing vacancies.

There is a small pressure for some who have been identified as having potentially been paid incorrectly, for which review is still underway through HR and is hoped to be resolved soon.

Some pressure potentially remains re prior years' PAIAW still outstanding – with claimants now being in the hand of CLO (and some of whom have now recently been paid.) This was accrued in 2022 and again at March 2023.

Additional, in the previous year, some costs of the project works started in 2021/22 re the eRostering project *(see para 3.2)*, M365 licences, and related pressures were accrued to fund an element of anticipated costs in 2022/23 – from this any unutilised elements have been carried forward to 2023/24.

3.2 Key financial pressures / potential benefits.

Revenue (RRL): -

Covid-19
Some posts have been reviewed for permanency, and a schedule of such posts is collated for review and consideration.

eRostering Project
While provision was noted for the contractual implementation costs of the eRostering project in 2022/23, this project is now rescheduled nationally by NSS to implement across 2023/24 and 2024/25. Additionally, currently unfunded are the additional posts potentially required in order to manage this implementation – being two posts requiring an annual funding of approx. £83k. This pressure has been highlighted.

Clinical Model review update
Current indications are the budget for overtime remains, savings targets have been set at 2%, which is anticipated from leavers at higher points in the bands' scales being replaced with starters at lower points of the scales.

Energy and inflation increases
The rising costs of energy supplies and the knock-on effect on other supply chain deliverables will continue to be closely monitored as it is expected that there could be significant pressure in 2023/24 – previously estimated at an increase of £300k, this has now been revised to £550k.

Extra PH for Platinum Jubilee
It is noted that there is the cost of one day's additional holiday in 2022/23, recurring in 2023/24 for the Coronation holiday.

Benefits
Travel underspend has resulted in budgets being reduced in 2023/24, to reflect changed ways of working.

3.3 2023/24 Draft Budget

The 2023/24 final budget template required by SG has been submitted, including revised savings requirements of £0.8m, with forecast breakeven.

Energy cost increases are anticipated in the coming year due to market price increases, and pressures are also noted for taking forward of new posts and structures established through Covid.

While the capital budget for 2023/24 remains at a recurring level of £269k, capital priorities are monitored and agreed through the Capital Group, and requirements for spend in the coming year

have been notified to CMT – also noting that additional project funding will be considered when appropriate for any priority projects not affordable through the recurring funding.

3.4 Year-to-date position 2023/24 – 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 2	Budget WTE	Actual WTE
Nursing And Ahp's	22,270	3,935	4,264	(329)	403.08	406.39
Security And Facilities	6,476	1,130	1,185	(55)	123.82	113.69
Utilities (extracted from above)	**732**	**122**	**197**	**(75)**		
Medical	3,270	548	548	(0)	22.75	16.97
Chief Exec	2,340	397	354	43	26.07	21.86
Human Resources Directorate	1,047	182	169	12	16.30	14.96
Finance	2,861	492	541	(49)	29.18	31.74
Cap Charges	2,646	441	467	(26)	0.00	
Misc Income	(200)	(33)	(77)	44	0.00	0.00
Central Reserves	1,438	319	7	312	0.00	0.00
	42,881	**7,532**	**7,655**	**(123)**	**621.20**	**605.61**

Nursing
Quarter 1 spend is being assessed against budgets to confirm accuracy of forecasting.
Psychology vacancies have offset some ward nursing overspend.
PAIAW monies not released in April and May, together with review of overtime in April and May will assess release of the overtime budget (phased through the year and to be adjusted from completion of quarter 1).
Benefit is noted from leavers being replaced by new starts in year, which will contribute to savings.

Security & Facilities
Utilities has been extracted from Security to show separately in order not to distract the directorate budget from core activity.
There are remaining covid pressures for disposable items being used for patient food delivery – and food price increases are causing pressure in the kitchen and staff restaurant costs.
Repairs spending continues to be a significant pressure in Estates.

Medical
Base budgets were based on March salaries and inflated by 2.5% for expected pay uplift in 23/24; these will be reviewed once the pay circular is received. Quarter 1 income is yet to be recognised, which will be applied from June 2023.

CE – Benefit is noted from vacancies.

HR – Benefit is noted from vacancies.

Finance
eHealth cost pressures are noted, while awaiting confirmation of allocation of strategic monies for release against staffing costs.

Capital Charges
We await budget confirmation from NSS of the required change to the allocation (core to non-core adjustment) which will be issued to match the expected outturn.

Miscellaneous Income (MI)

The budget recognises income billed for exceptional circumstance patients, with appropriate risk provision for older balances with boards with whom recoverable balances are being discussed.

Central reserves
A small proportion has been deferred for utilisation in 23/24 (subject to audit review).

4 ASSESSMENT – SAVINGS

Savings are phased evenly over the year (twelfths), and equate to approx. £0.8m (2%).

No savings have yet been allocated through April and May and these will be adjusted for in June for monthly tracking thereafter.

It should be noted that of the Hospital's budget only 15% of costs are non-pay related, certain boards also treat vacancy savings, or a proportion thereof, as recurring savings, we still class as non-recurring.

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 2022/23 remained at £0.220m, with 2023/24 to be confirmed.

5 CAPITAL RESOURCE LIMIT

The recurring capital allocation anticipated from Scottish Government for 2022/23 is £0.269m, which is anticipated to be fully utilised with capital projects planned and agreed through the Capital Group. Certain projects are likely to require requests on a project-by-project basis to SG for additional funding, including anticipated backlog maintenance work required on the Hospital.

With regard to the Perimeter Security Project allocation, there are elements of unforeseen delays in the project – now likely to be completing in 2023/24 Q3 – requiring carry forward of unspent monies. SG are fully up-to-date with the anticipated project outturn and conclusion.

6 RECOMMENDATION

The Board is asked to note the following position and forecast.

Revenue
The year to date position is an over spend of £0.123m. Forecast for the year remains breakeven.

Capital
With little spend yet incurred in April and May as projects are at the evaluation and quotation stage, forecast for the year is for full utilisation of the annual allocation.

MONITORING FORM

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

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 June 2023
Agenda Reference:	Item no: 25
Sponsoring Director:	Chief Executive
Author:	Head of Corporate Planning and Performance Clinical Quality Facilitator
Title of Report:	Performance Report 2022/2023 and Comparative Annual Figures.
Purpose of Report:	For Noting

1 SITUATION

This report presents a high-level summary of organisational performance for the year from 1st April 2022 until 31st March 2023. Trend data is provided to enable comparison with previous performance. The national standards directly relevant to the State Hospital are Psychological Therapies, Waiting Times and Sickness Absence. Additional local Key Performance Indicators (KPIs) are reported to the Board and are included in this report. Board planning and performance are monitored by Scottish Government through the Annual Operational Plan (AOP).

2 BACKGROUND

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

3 ASSESSMENT

The following sections contain the KPI data for 2022/23 and highlight any areas for improvement through a deep dive analysis for KPI's that have missed their targets.

There are two updated KPIs for 2022/2023 that have achieved target, these are:

- Patients will undertake an annual physical health review
- Patients will undertake 150 minutes of exercise each week

There are four KPIs that have missed their target this year, these are:

- Patients will have their care and treatment plans reviewed at 6 monthly intervals.
- Patients will have a healthier BMI.
- Sickness absence (National HEAT standard is 4%)
- Patients will commence psychological therapies <18 weeks from referral date

Item	Principles	Performance Indicator	Target	RAG	22/23	21/22	20/21	19/20	18/19		LEAD
1	8	Patients have their care and treatment plans reviewed at 6 monthly intervals	100%	**A**	91.70%	92.67%	94.40%	91.73%	96.9%	Average figure from April 2022 – March 2023.	**LT**
2	8	Patients will be engaged in psychological treatment	85%	**G**	83.2%	85.56%	86.74%	87.93%	92.8%	Average figure from April 2022 – March 2023.	**KMcC**
3	8	Patients will be engaged in off-hub activity centres	90%	**-**	-	-	-	83%	81.7%	This indicator was closed in June 2020 to accommodate engagement during restrictions.	**KMcC**
3.1	8	Patients will be engaged in off-hub activity centres during COVID-19	90%	**G**	90.92%	92.47%	83.33%	-	-	Average figure from April 2022 – March 2023.	**KMcC**
4	8	Patients will be offered an annual physical health review.	90%	**-**	-	51.78%	56.67%	98.48%	93%	This indicator was closed in March 2022 with restructured reporting commencing in April 22 (see 4.1).	**LT**
4.1	8	Patients will undertake an annual physical health review	90%	**G**	98.2%	-	-	-	-	Average figure from April 2022 – March 2023.	**LT**
5	8	Patients will undertake 90 minutes of exercise each week (Annual Audit)	80%	**-**	-	78.75%	75.00%	60.70%	56.3%	This indicator was closed in March 2022 to accommodate new guidance with reporting commencing in April 2022 (see 5.1).	**KMcC**
5.1	8	Patients will undertake 150 minutes of exercise each week (Annual Audit)	60%	**G**	63.35%	-	-	-	-	Average figure from April 2022 – March 2023.	**KMcC**
6	8	Patients will have a healthier BMI	25%	**R**	9.5%	10%	10.50%	8.75%	13.7%	Average figure from April 2022 – March 2023.	**LT**
7	5	Sickness absence (National HEAT standard is 4%)	** 5%	**R**	7.68%	6.39%	5.30%	5.92%	8.26	Average figure from April 2022 – March 2023.	**LMcG**
8	5	Staff have an approved PDR	*80%	**G**	83.35%	85.25%	80.58%	86.68%	80.9%	Average figure from April 2022 – March 2023.	**LMcG**
9	1, 3	Patients transferred/discharged using CPA	100%	**G**	100%	100%	100%	100%	97%	Average figure from April 2022 – March 2023.	**KMcC**
10	1, 3	Patients requiring primary care services will have access within 48 hours	*100%	**G**	100%	100%	100%	100%	100%	Average figure from April 2022 – March 2023.	**LT**
11	1, 3	Patients will commence psychological therapies <18 weeks from referral date	**100%	**A**	91.43%	98.66%	97.66%	99.78%	98.5%	Average figure from April 2022 – March 2023.	**KMcC**
14	2, 6, 7, 9	Patients have their clinical risk assessment reviewed annually.	100%	**G**	95.42	96.49%	95.35%	97.68%	99%	Average figure from April 2022 – March 2023.	**LT**
15	2, 6, 7, 9	Attendance by all clinical staff at case reviews	Individual	**-**	63.7% overall	69.3% overall	67.40% overall	71.5% overall	65.6% overall	Average figure from April 2022 – March 2023.	**All Leads**

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

Target: 100%

Data for 2022/23: 91.7%

Performance Zone: Amber

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

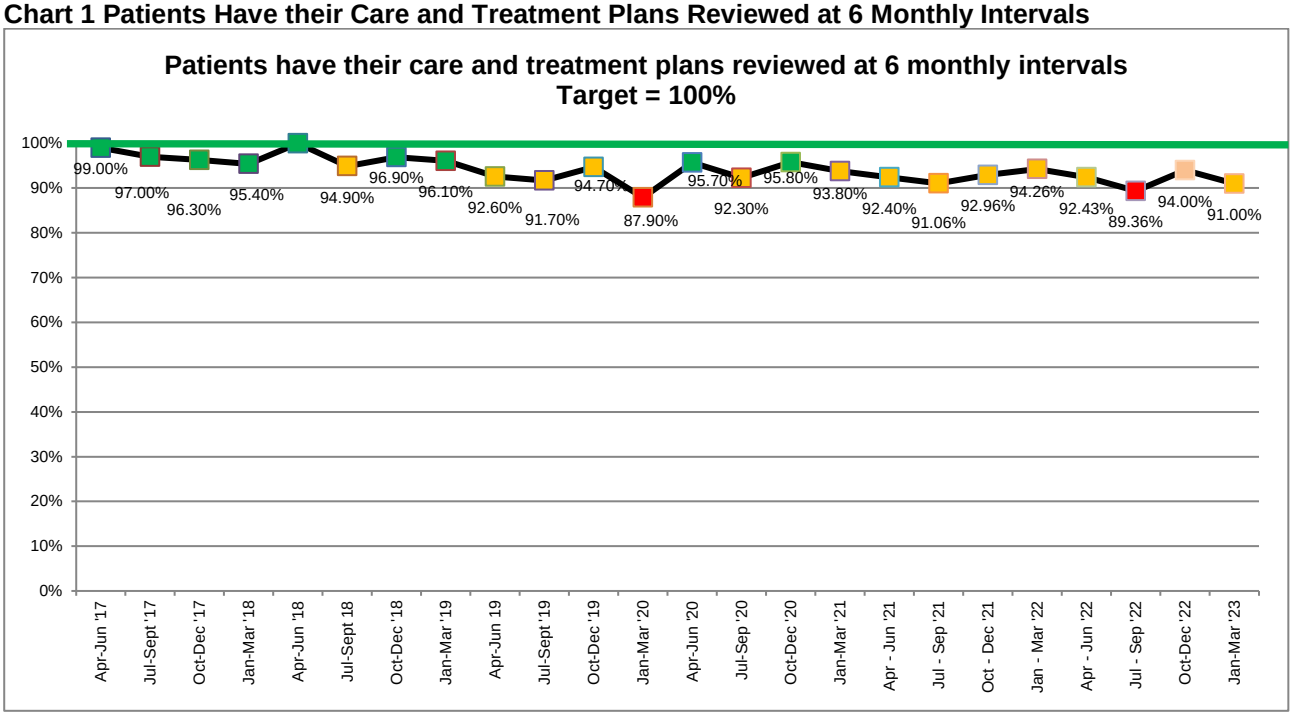
Performance Indicator	Target	RAG Q1 22/23	RAG Q2 22/23	RAG Q3 22/23	RAG Q4 22/23	22/23	21/22	20/21	19/20	18/19
Patients have their care and treatment plans reviewed at 6 monthly intervals	100%	A	R	A	A	91.7	92.67%	94.40%	91.73%	96.9%

Performance has continued to decrease in 2022/23 as the annual average for this indicator was 0.97% lower than that of 2021/22. Three of the four quarters of 22/23 were within the amber performance zone, with the overall annual performance also rated as amber.

There were 28 separate instances during this reporting year where a patient waited beyond the specified 6 months of reviewing their care and treatment plans. This is an increase of 12 from the 16 instances the previous year. In addition, there were 20 separate instances of patients who did not have their documentation uploaded to RiO within the specified period for their care and treatment plan at that time. This is an improvement of one from the previous annual review period.

All dates are set in line with the relevant date of an annual review or renewal followed by a 6 monthly review after that. The MHPSG are reviewing the CPA process and this is being governed through Clinical Governance. 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.

Chart 1 Patients Have their Care and Treatment Plans Reviewed at 6 Monthly Intervals



No 2: Patients will be engaged in Psychological Treatment

Target: 85%

Data for 2022/23: 83.2%

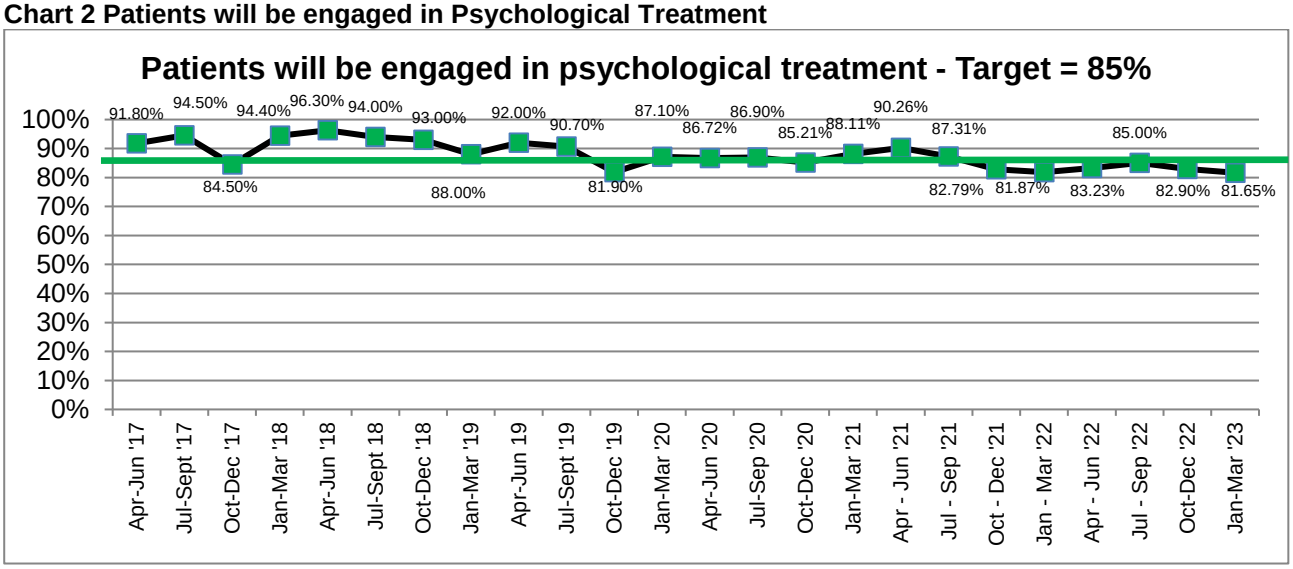
Performance Zone: Green

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.

Performance Indicator	Target	RAG Q1 22/23	RAG Q2 22/23	RAG Q3 22/23	RAG Q4 22/23	22/23	21/22	20/21	19/20	18/19
Patients will be engaged in psychological treatment	85%	G	G	G	G	83.2%	85.56%	86.74%	87.93%	92.8%

Performance over the course of the year remained within the green performance zone. The annual average of 83.2% has continued to reduce year on year from 92.8% in 2018/19.

Chart 2 Patients will be engaged in Psychological Treatment



No 3.1: Patients will be engaged in Off-Hub Activity Centers

Target: 90%

Data for 2022/23: 90.92%

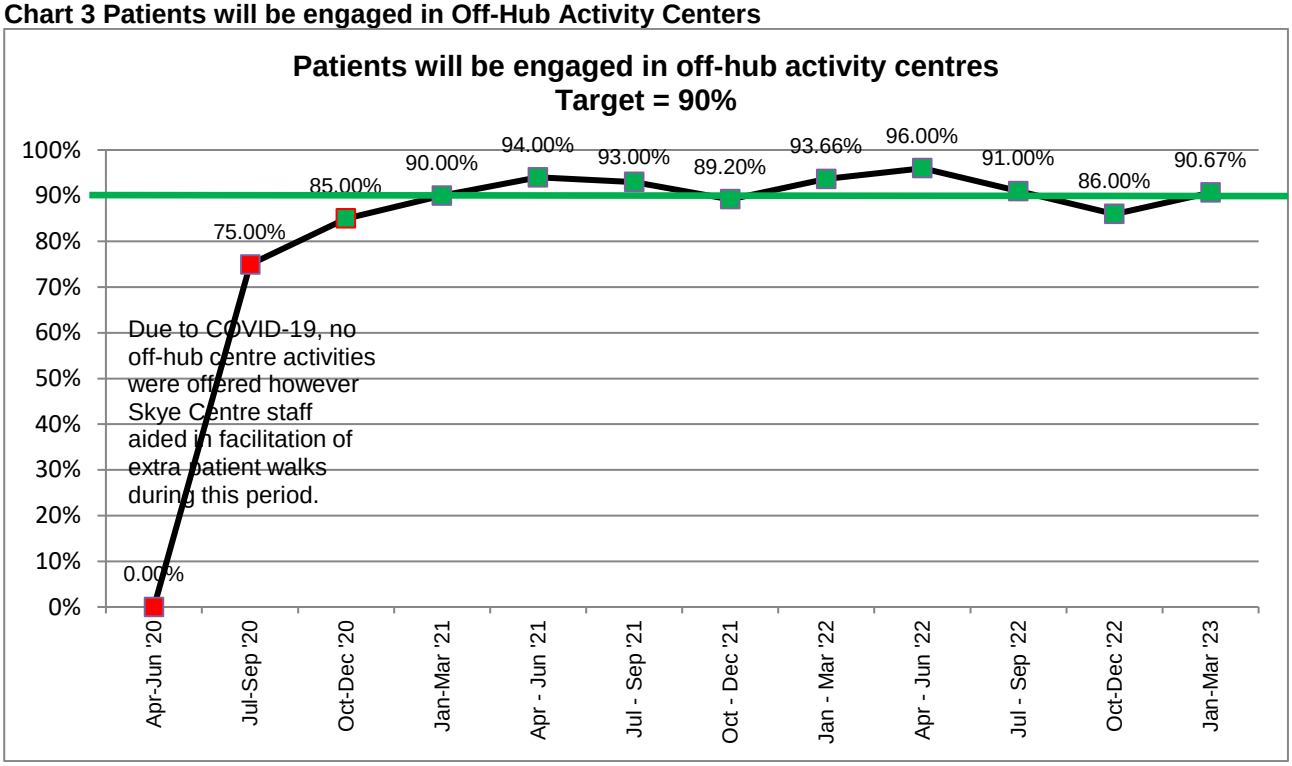
Performance Zone: Green

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 are recognised as therapeutic activities. This will continue to be reported through the Activity Oversight Group (AOG).

Performance Indicator	Target	RAG Q1 22/23	RAG Q2 22/23	RAG Q3 22/23	RAG Q4 22/23	22/23	21/22	20/21	19/20	18/19
Patients will be engaged in off-hub activity centers during COVID-19	90%	G	G	G	G	90.92%	92.47%	83.33%	-	-

This indicator averaged at 90.92% for this reporting year; a 1.55% decrease on last years' figure.

Chart 3 Patients will be engaged in Off-Hub Activity Centers



No 4.1: Patients will undertake an Annual Physical Health Review

Target: 90%

Data for 2022/23: 98.2%

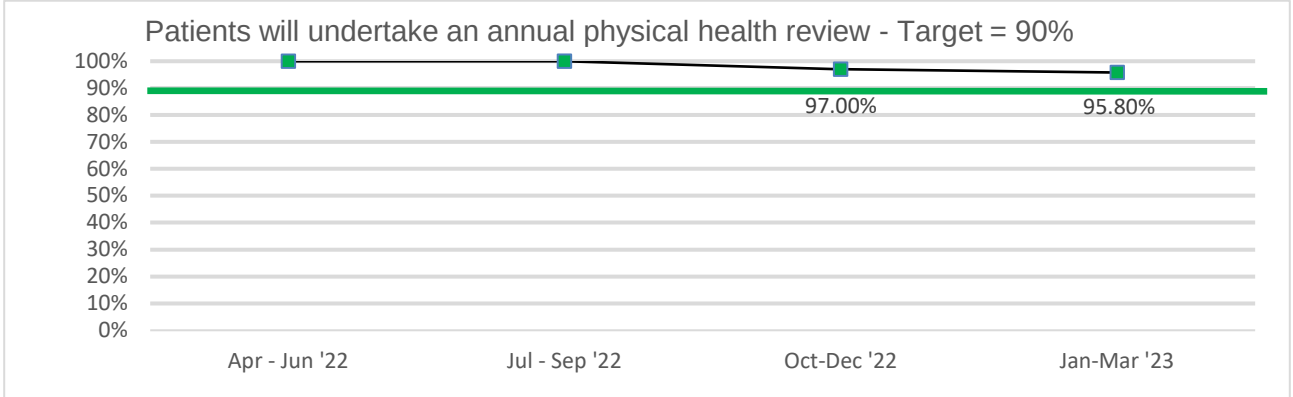
Performance Zone: Green

This indicator is linked to the National Health and Social Care Standards produced by Healthcare Improvement Scotland (HIS).

Performance Indicator	Target	RAG Q1 22/23	RAG Q2 22/23	RAG Q3 22/23	RAG Q4 22/23	22/23
Patients will be offered an annual physical health review	90%	G	G	G	G	98.2%

The indicator previously measured the offer of an annual health review and not the uptake. As at 1 April 2022, this KPI was amended to incorporate the uptake of an annual physical health review by all of our patients. 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.

Chart 4 Patients will undertake an Annual Physical Health Review



No 5.1: Patients will be Undertake 150 Minutes of Exercise Each Week

Target: 60%

Data for 2022/23: 63.35%

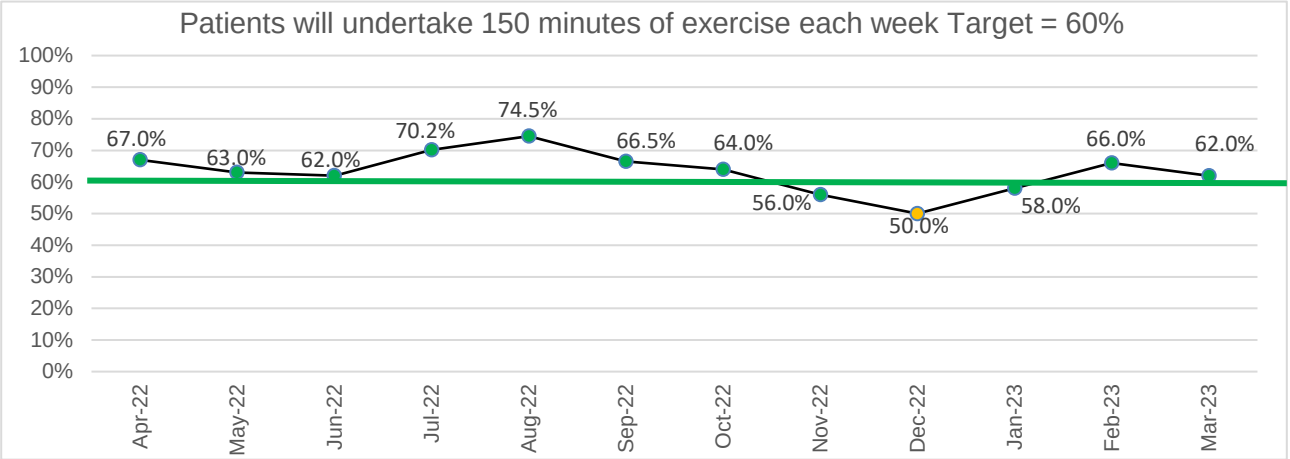
Performance Zone: Green

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

Performance Indicator	Target	RAG Q1 22/23	RAG Q2 22/23	RAG Q3 22/23	RAG Q4 22/23	22/23
Patients will undertake 150 minutes of exercise each week	60%	G	G	G	G	63.35%

At the Board meeting in June 2022, the Board agreed to change the corporate KPI 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 WHO and reviewed by the Physical Health Steering Group (PHSG). This change was effective from 1st April 2022 and is currently under review to assess whether the target should be increased to 70% for 2023/24.

Chart 5 Patients will be Undertake 150 Minutes of Exercise Each Week



No 6: Patients will have a Healthy BMI

Target: 25%

Data for 2022/23: 9.5%

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.

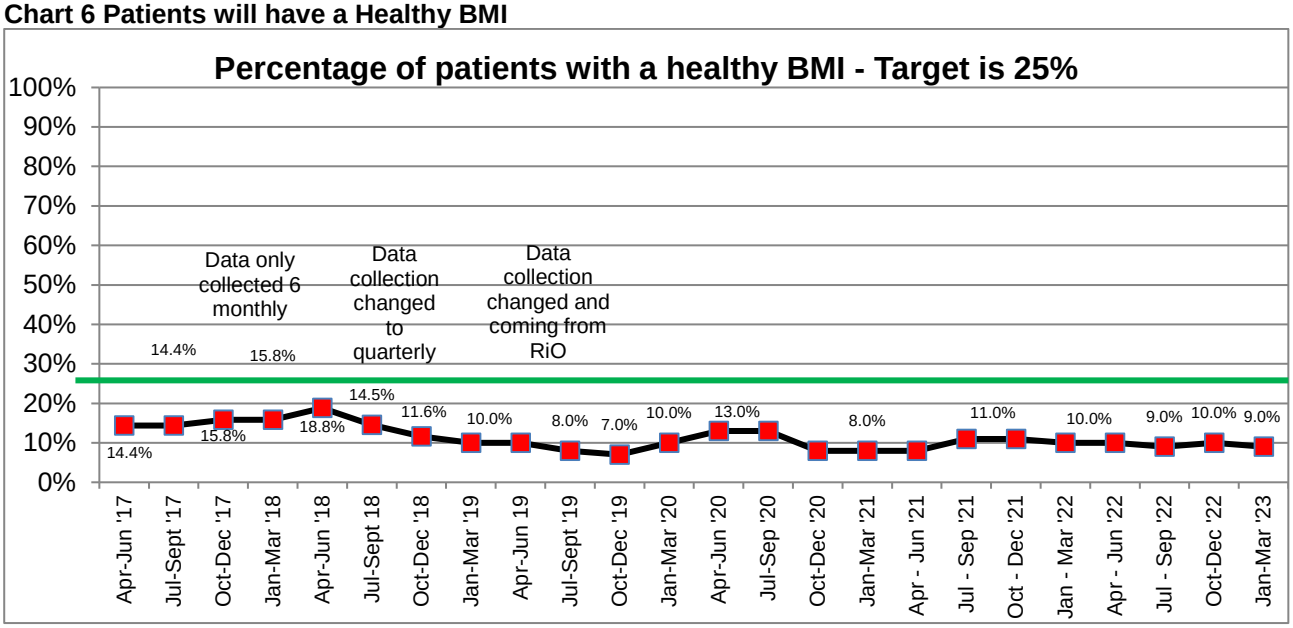
Performance Indicator	Target	RAG Q1 22/23	RAG Q2 22/23	RAG Q3 22/23	RAG Q4 22/23	22/23	21/22	20/21	19/20	18/19
Patients will have a healthier BMI	25%	R	R	R	R	9.5%	10%	10.50%	8.75%	13.7%

The average percentage of patients who have a healthier BMI decreased from 10% in the previous year to 9.5% in this reporting year. In Q1 there was a maintenance of 10% from Q4 of the previous year which was followed by a 1% decrease to 9% in Q2. There was an increase of 1% in Q3 to 10% and then a further reduction of 1% to 9% in Q4. This indicator remains within the red performance zone for this reporting year.

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.

Chart 6 Patients will have a Healthy BMI



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

Target: 5%

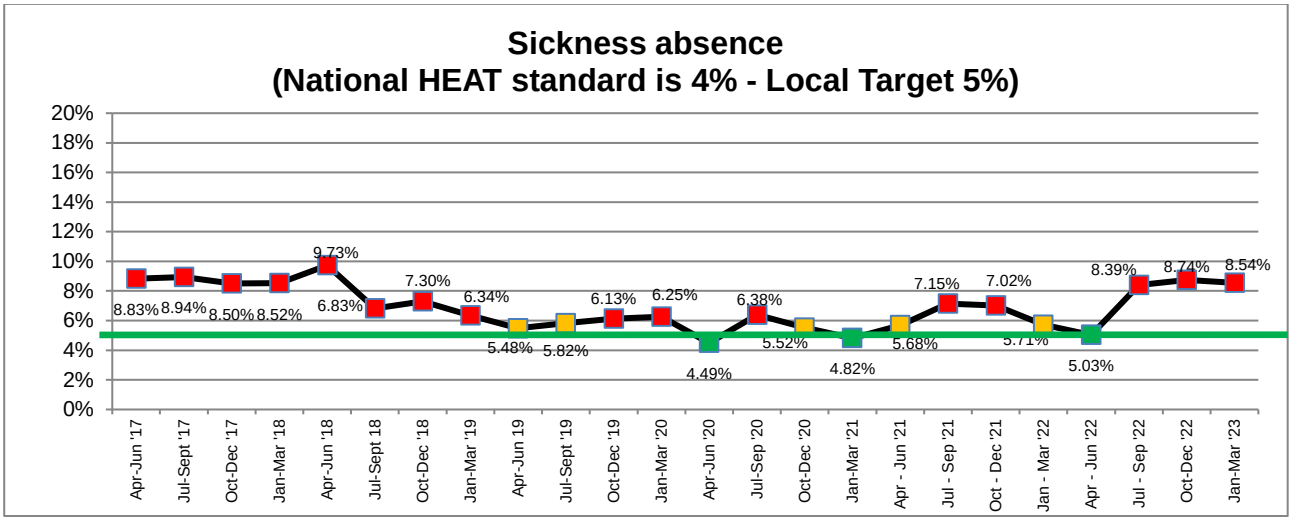
Data for 2022/23: 7.68%

Performance Zone: Red

Performance Indicator	Target	RAG Q1 22/23	RAG Q2 22/23	RAG Q3 22/23	RAG Q4 22/23	22/23	21/22	20/21	19/20	18/19
Sickness absence rate (National HEAT standard is 4%)	** 5%	G	R	R	R	7.68%	6.39%	5.30%	5.92%	8.26%

In the reporting period 1 April 2022 to 31 March 2023, the rate of absence was 7.68% compared to 6.39% in the previous year - this is a continued increase to sickness levels by 1.29% which is against a 5% target. In Q1 there was a reduction to 5.03% from 5.71% inQ4 of the previous year which was followed by a 3.27% increase to 8.39% in Q2. There was a continued increase to 8.74% in Q3 and then a slight reduction to 8.54% in Q4. TSH remains in the red performance zone for this reporting year.

Chart 7 Sickness Absence



Quarterly Performance Review meetings are held with Directorates and absence management is a focus for these meetings in areas where performance can be improved. The Staff Governance Committee have agreed to establishment of a Task and Finish Group to develop and co-ordinate an action plan with a range of activities to address attendance management and support staff.

The introduction of the new Occupational Health (OH) contract will enable closer working with practitioners, line managers, employees and HR whilst the introduction of best practice 'Once for Scotland' documentation and processes should ease sharing of information and encourage return to work or maintenance of healthy attendance at work.

The following pieces of work are also being progressed:

- Diversifying the Early Intervention service to introduce a 'triage' service for managers and employees to seek advice on range of matters pro-actively.
- Introduction of a focused action plan within HR to utilise a new role that has been created (Assistant HR Advisor), with the intention to support line managers with minimising sickness absence, identifying trends and advising appropriate interventions in a timely manner. Monitoring compliance with policy stages, return to work interviews and stage meetings as well as making sure there is a joint plan between line manager, employee, OH and HR in place for every person who is on long term sickness absence.
- In addition to the Once for Scotland Policy, line managers have been given additional resources to support good quality return to work interviews & training is scheduled to be delivered in partnership on the person centred nature of the policy.

In addition, the Workforce Governance Group review absence levels across the Directorates on a monthly basis.

No 8: Staff have an Approved PDR

Target: 80%

Data for 2022/23: 83.35%

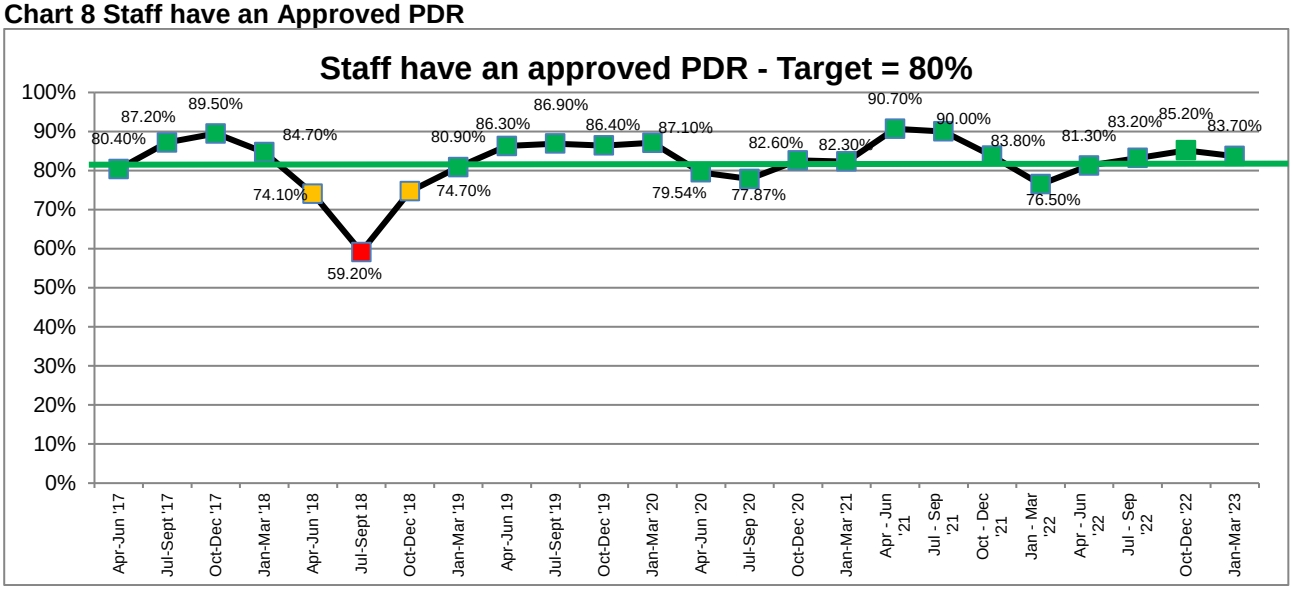
Performance Zone: Green

This indicator relates to the National Workforce Standards; measuring the percentage of staff with a completed PDR within the previous 12 months.

Performance Indicator	Target	RAG Q1 22/23	RAG Q2 22/23	RAG Q3 22/23	RAG Q4 22/23	22/23	21/22	20/21	19/20	18/19
Staff have an approved PDR	80%	G	G	G	G	83.35	85.25%	80.58%	86.68%	80.9%

The PDR compliance level at 31 March 2023 was 83.7% - the reporting year averaging at 83.35%. This is a reduction of 1.9% from the 2021/22 figure of 85.25%. This indicator has consistently been within the green zone since March of 2019. Fluctuations have occurred throughout this time however compliance has been maintained.

Chart 8 Staff have an Approved PDR



No 9: Patients are Transferred/Discharged using CPA

Target: 100%

Data for 2022/23: 100%

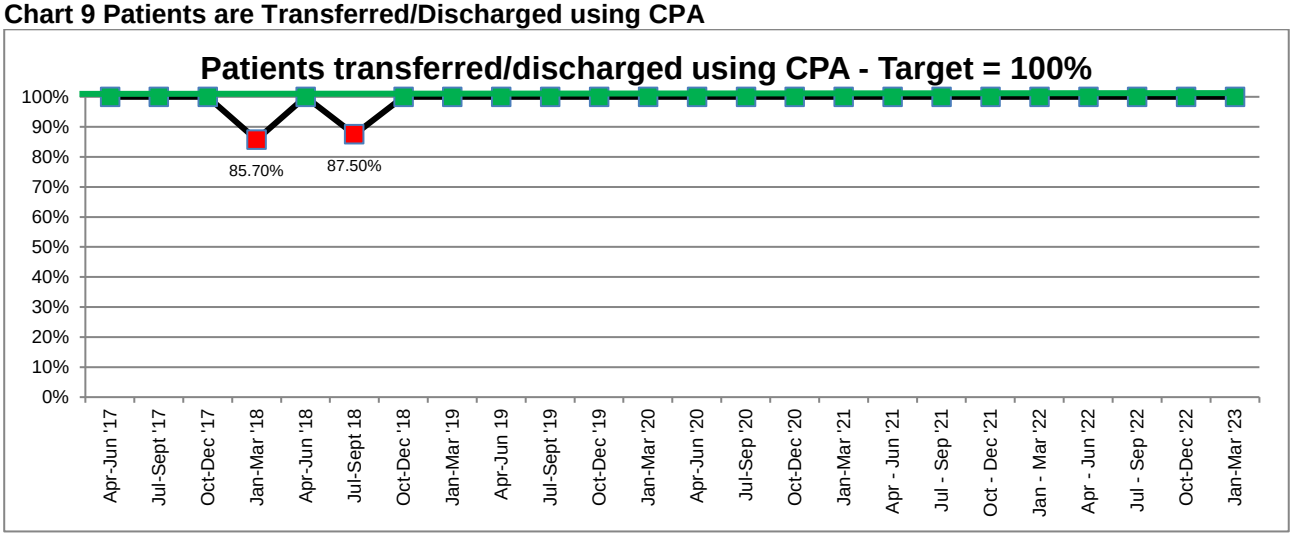
Performance Zone: Green

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.

Performance Indicator	Target	RAG Q1 22/23	RAG Q2 22/23	RAG Q3 22/23	RAG Q4 22/23	22/23	21/22	20/21	19/20	18/19
Patients transferred/discharged using CPA	100%	G	G	G	G	100%	100%	100%	100%	97%

100% of patients were discharged / transferred using the Care Programme Approach (CPA).

Chart 9 Patients are Transferred/Discharged using CPA



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

Target: 100%

Data for 2022/23: 100%

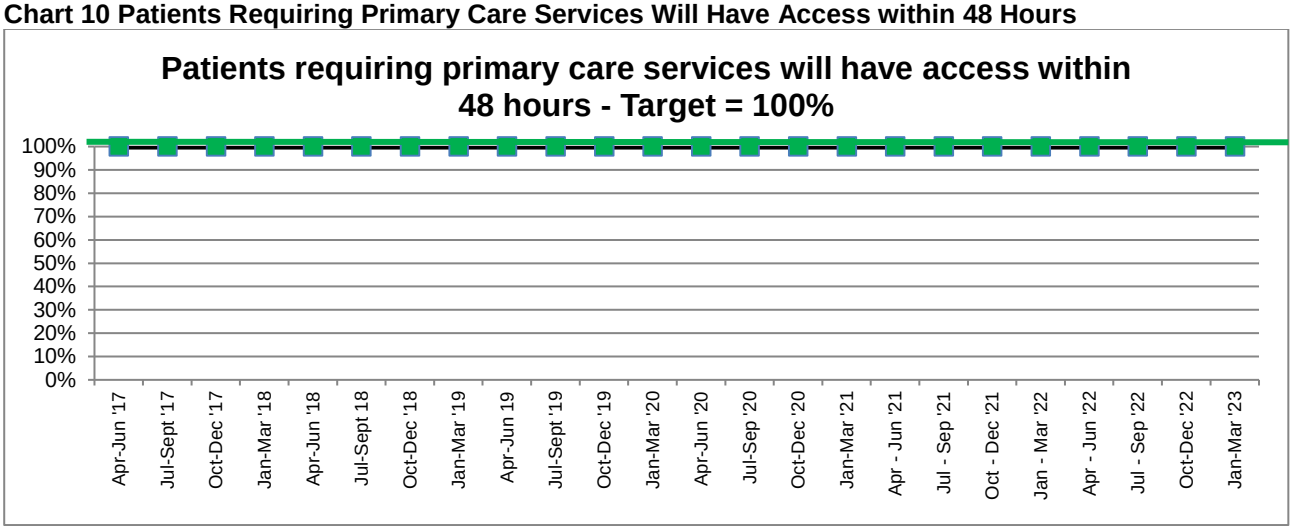
Performance Zone: Green

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.

Performance Indicator	Target	RAG Q1 22/23	RAG Q2 22/23	RAG Q3 22/23	RAG Q4 22/23	22/23	21/22	20/21	19/20	18/19
Patients requiring primary care services will have access within 48 hours	*100%	G	G	G	G	100%	100%	100%	100%	100%

This indicator has consistently stayed at full compliance since its data collection began.

Chart 10 Patients Requiring Primary Care Services Will Have Access within 48 Hours



No 11: Patients will Commence Psychological Therapies <18 Weeks from Referral Date

Target: 100%

Data for 2022/23: 91.43%

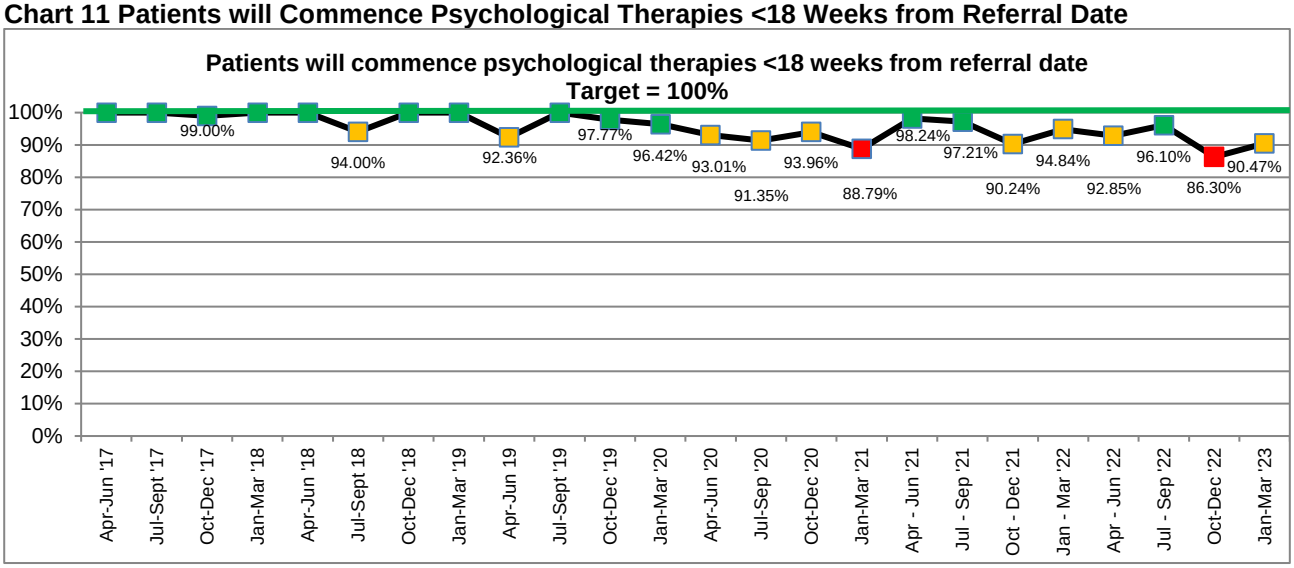
Performance Zone: Amber

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 Scottish Government Target for this KPI is 90%.

Performance Indicator	Target	RAG Q1 22/23	RAG Q2 22/23	RAG Q3 22/23	RAG Q4 22/23	22/23	21/22	20/21	19/20	18/19
Patients will commence psychological therapies <18 weeks from referral date	**100%	A	G	R	A	91.43%	98.66%	97.66%	99.78%	98.5%

There was a decrease by 7.23% in this year's figure against 2021/22's figure. Compliance has moved into the amber zone for this indicator. Recording issues have been identified and an improvement plan is in place working with e-health colleagues to streamline the data and ensure consistency and quality of data. Group and individual treatment recording are now considered together to map patient needs with plans for delivery of treatment. Monthly review of patient needs is also planned as part of the regular consultant meetings.

Chart 11 Patients will Commence Psychological Therapies <18 Weeks from Referral Date



No 14: Patients have their Clinical Risk Assessment Reviewed Annually

Target: 100%

Data for 2022/23: 95.42%

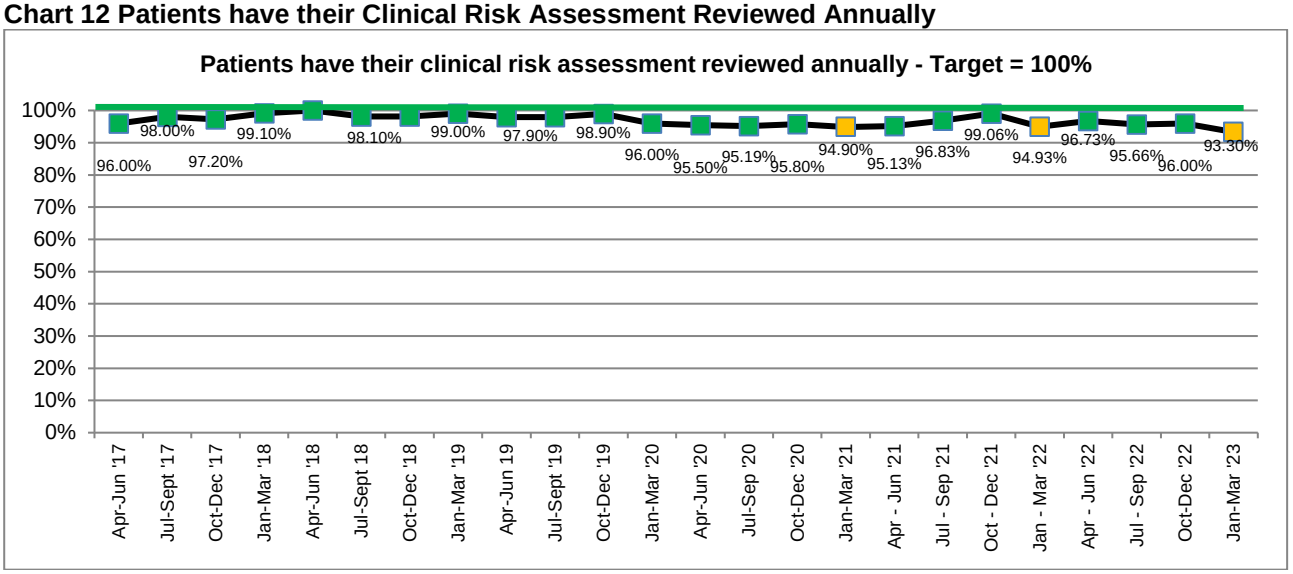
Performance Zone: Green

The indicator links with the Mental Health Care and Treatment Act Scotland, 2003. Examples of clinical risk assessments would be a HCR20 / SARA.

Performance Indicator	Target	RAG Q1 22/23	RAG Q2 22/23	RAG Q3 22/23	RAG Q4 22/23	22/23	21/22	20/21	19/20	18/19
Patients have their clinical risk assessment reviewed annually.	100%	G	G	G	A	95.42%	96.49%	95.35%	97.68%	99%

The average figure for this indicator in year 2022/23 is 95.42% and only during Q4 did we see a move into the amber zone. This is similar to the pattern during the last review period. Monitoring practices and auditing of the system integrated in 2017 are ongoing.

Chart 12 Patients have their Clinical Risk Assessment Reviewed Annually



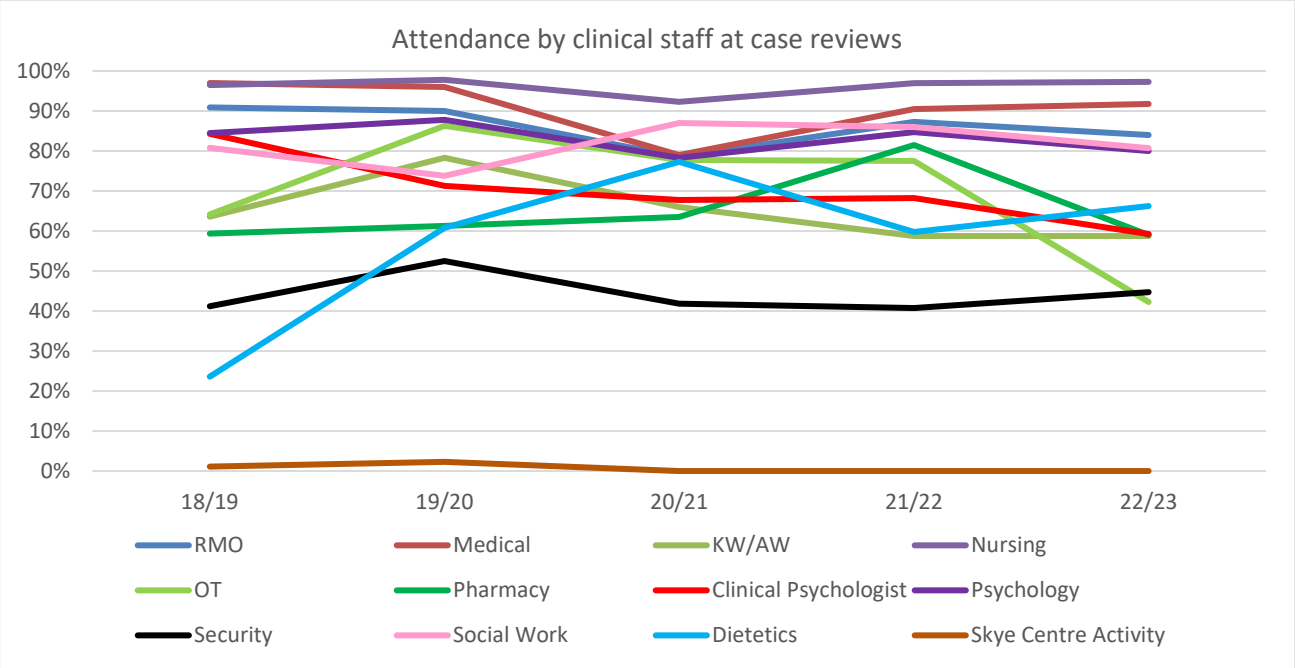
No 15 Attendance by clinical staff at case reviews.

The table below provides comparative data on the extent to which professions met their attendance target. 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.

Table 2 Attendance by clinical staff at case reviews

Professional Group	Target	18/19	19/20	20/21	21/22	22/23	Increase/Decrease from previous year
RMO	90%	90.9%	90%	78.5%	87.25%	84%	-3.25%
Medical	100%	97%	96%	79%	90.5%	91.75%	1.25%
KW/AW	80%	63.6%	78.3%	66%	58.75%	58.75%	0.00%
Nursing	100%	96.5%	97.8%	92.3%	97%	97.25%	0.25%
OT	80%	64.2%	86.3%	77.8%	77.5%	42.25%	-35.25%
Pharmacy	60%	59.4%	61.3%	63.5%	81.5%	59%	-22.50%
Clinical Psychologist	80%	84.3%	71.3%	67.8%	68.25%	59.25%	-9.00%
Psychology	100%	84.5%	87.8%	78.3%	84.75%	80%	-4.75%
Security	60%	41.2%	52.5%	41.8%	40.75%	44.75%	4.00%
Social Work	80%	80.8%	73.8%	87%	86%	80.75%	-5.25%
Dietetics	tbc	23.6%	60.8%	77.3%	59.75%	66.25%	6.50%
Skye Centre Activity	tbc	1.1%	2.3%	0%	0%	0%	No change
Hospital Wide	**n/a**	**65.6%**	**71.5%**	**67.4%**	**69.3%**	**63.67%**	-5.63%

Chart 13 Attendance by clinical staff at case reviews



RMO – during 2022/23, there was a decrease in RMO attendance at case reviews: the figure reduced by 3.25%. This profession's average remained in the green zone for this reporting year.

Medical – during 2022/23, there was 1.25% rise in medical attendance at case reviews. This increase moves this profession into the green zone for this reporting year.

Key Worker/Associate Worker – there has been maintenance in attendance for 2022/23 at 58.75%. This means that they remain in the red zone for this reporting year.

Nursing – attendance from nursing during 2022/23 has increased by 0.25%. This profession remains in the green zone for this reporting year.

Occupational Therapy – during 2022/23, attendance from occupational therapy has significantly decreased by 35.25% from the previous year. This profession moves in to the red zone for this reporting year.

Pharmacy – although there has been a notable decrease in this reporting year of 22.5%, this profession has remained in the green zone for this reporting year.

Clinical Psychologist – there has been a slight decrease of 9% attendance for 2022/23. This means that this profession has remained in the red zone for this reporting year.

Psychology – during 2022/23, there was a reduction of 4.75% in attendance for this department. This profession remains in the red zone.

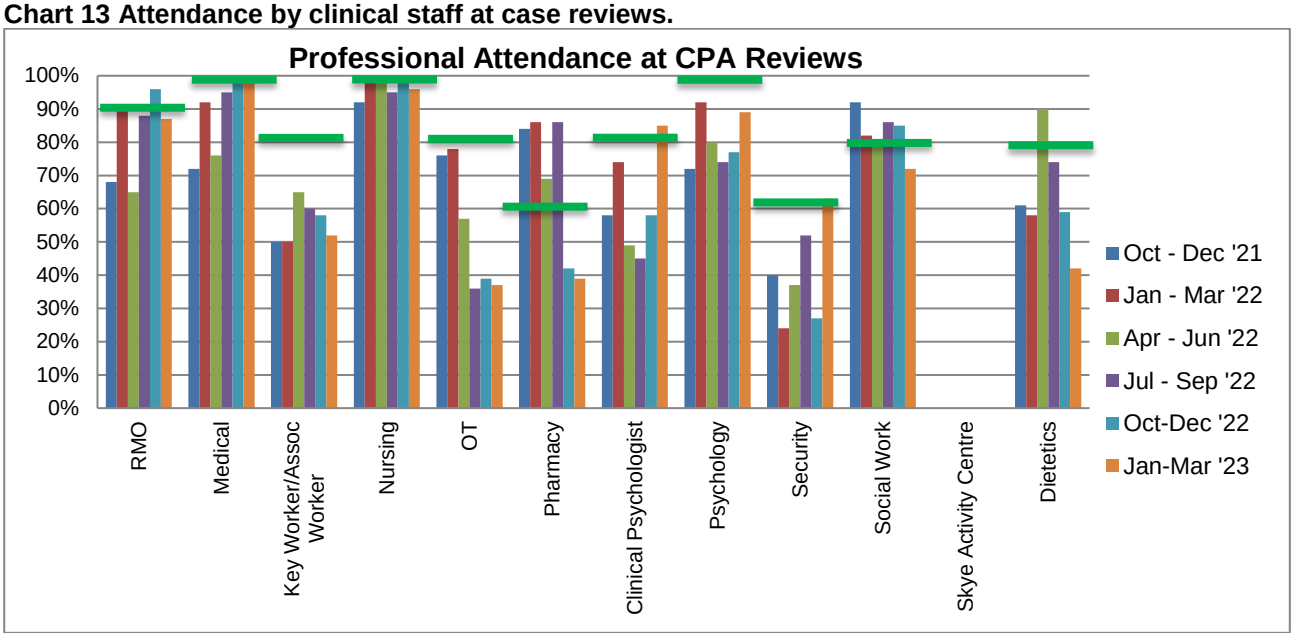
Security – there was a 4% increase in Security attendance during 2022/23. The profession remains in the red zone for this reporting year.

Social Work – there has been a 5.25% decrease in attendance at case reviews. This profession remains in the green zone for this reporting year.

Dietetics – during 2022/23, attendance from dietetics has increased by 6.5. This profession is in the red zone for this reporting year.

Skye Centre Activity – during 2022/23, there was no attendance from Skye Centre staff at case reviews. This figure is the same as the previous reporting year. There is no target for this group as of yet.

Chart 13 Attendance by clinical staff at case reviews.



4 RECOMMENDATION

The Board are 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 Annual Delivery Plan and Workforce Strategy is a key metric in supporting attendance management
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?	Strategic Planning and Performance Group
Risk Assessment (Outline any significant risks and associated mitigation)	No implications identified .
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 Q3	RAG Q4	Overall attendance Jan – Mar 2023 (n=46)	Overall attendance Oct – Dec 2022 (n=52)	Overall attendance Jul – Sep 2022 (n=42)	Overall attendance Apr – Jun 2022 (n=51)
15	T	2, 6, 7, 9	Attendance by all clinical staff at case reviews	RMO **(LT)**	90%	G	G	87%	96%	88%	65%
				Medical **(LT)**	100%	G	G	98%	98%	95%	76%
				Key Worker/Associate Worker **(MR)**	80%	R	R	52%	58%	60%	65%
				Nursing **(MR)**	100%	G	G	96%	100%	95%	98%
				OT**(MR)**	80%	R	R	37%	39%	36%	57%
				Pharmacy **(LT)**	60%	R	R	39%	42%	86%	69%
				Clinical Psychologist **(JM)**	80%	R	G	85%	58%	45%	49%
				Psychology **(JM)**	100%	R	R	89%	77%	74%	80%
				Security **(DW)**	60%	R	G	63%	27%	52%	37%
				Social Work **(KB)**	80%	A	G	72%	85%	86%	80%
				Skye Activity Centre **(MR)** (only attend annual reviews)	tbc			0%	0%	0%	0%
				Dietetics **(MR)** (only attend annual reviews)	80%	R	R	42% (n=26)	59% (n=32)	74% (n=19)	90% (n=19)

APPENDIX 2: QUARTERLY KEY PERFORMANCE INDICATORS FOR 2022-2032

Performance Indicator	Target	RAG Q1 22/23	RAG Q2 22/23	RAG Q3 22/23	RAG Q4 22/23	Actual	Comment
Patients have their care and treatment plans reviewed at 6 monthly intervals	100%	A	R	A	A	91%	This indicator remains in the amber zone from Q3.
Patients will be engaged in psychological treatment	85%	G	G	G	G	82%	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	G	G	96%	96% compliance. Green compliance for this amended KPI.
Patients will undertake 150 minutes of exercise each week	60%	G	G	G	G	62%	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%	G	R	R	R	8.54%	January's figure was 9.24%, February's figure was 7.52% and March's figure was 8.85%.
Staff have an approved PDR	*80%	G	G	G	G	84%	This indicator has been within the green zone since March 2019.
Patients transferred / discharged using CPA	100%	G	G	G	G	100%	This indicator has been in the green zone since October 2018.
Patients requiring primary care services will have access within 48 hours	*100%	G	G	G	G	100%	This indicator remains 100% in Q4.
Patients will commence psychological therapies <18 weeks from referral date	**100%	A	G	R	A	90%	As at 31 March 2023, there was 1 instance of a patient waiting beyond the specified wait time
Patients have their clinical risk assessment reviewed annually.	100%	G	G	G	A	93%	As at 31 March 2023, there were 109 patients in the hospital. Nine were new admissions. Nine patients had an out of date or no risk assessment
Attendance at CPA Reviews (Refer to Appendix 1)							

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.

Paper No 23/58

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 June 2023
Agenda Reference:	Item No: 26
Sponsoring Director:	Director of Finance and eHealth
Author(s):	Director of Finance and eHealth
Title of Report:	NIS Review Summary
Purpose of Report:	For Noting

1 SITUATION

The State Hospital (TSH) was subject to a compliance progress review by Cyber Security Scotland during October 2022, with the next stage review due in October 2023.

2 BACKGROUND

In 2020 the Scottish Health Competent Authority commissioned a three-year programme of audits and reviews of health boards to evaluate compliance with the Network & Information Systems (NIS) regulations. The initial audit programme has been completed and unless incident reports or significant system changes in a health board merit a more frequent audit exercise, audits are conducted every third year. In intervening years, Compliance Reviews are being undertaken – to which this report relates - the primary objective of the review being to review progress on implementing the recommendations from the initial audit and progress on the control requirements.

3 ASSESSMENT AND OUTCOMES

A considerable amount of evidence is submitted up front to the reviewers – each piece of evidence requested for the review being "mapped" to one or more controls set out. The documentary evidence is then reviewed and assessed for compliance.

3.1 REVIEW

The 17 categories of the review are as follows –

- Organisational Governance
- Risk Management
- Supplier Management
- Asset Management
- Information Security Management

- People
- Services Resilience
- Access Control
- Media Management
- Environmental Security
- Physical / Building Security
- System Management
- Operational Security
- Network Security
- Incident Detection
- Incident Management
- Business Continuity

3.2 OUTCOMES AND NEXT STEPS

While the compliance status outcome from the 2022 review was raised from previous reviews, this was only from 28% to 36%. Although TSH has a strong approach to Information Security, the review highlighted the lack of one individual being in the dedicated post of IT Security Officer, which is seen as a key aspect. However, due to the size of our Board and eHealth team, this post is combined with other duties in the role of IM&T Senior Infrastructure Analyst & IT Security Officer – which is under review.

A significant programme of work is underway to reduce this level of risk exposure, and this is now progressing as a priority. The individual assessment points in the review have now all been confirmed with allocated responsibilities across directorates for provision of documented processes in support of compliance.

The process is underway to provide supporting evidence to each assessment point with an initial deadline of 30 June 2023 to allow full collation and internal review. A structured template has been provided for each action to be addressed, documented and then submitted for collation into the main audit submission.

These actions are being tracked fortnightly by the monitoring group (Director of Finance & eHealth, Head of eHealth and IT Security Officer – reporting to Chief Exec). There will then be time for subsequent appraisal of outstanding evidence to be identified before the external appraisal in October .

While the previous review was conducted wholly remotely, on 5 June 2023 the independent reviewed undertook a site visit at TSH which, with support predominantly from eHealth, Security and Estates, enable a fuller appraisal of the physical aspects of our site and systems. It had been felt previously that it is essential given the nature of TSH to be able to demonstrate physically a number of areas of compliance which have not been fully understood by the reviewer being limited by documentation only. We await the outcome from this review, which will be considered alongside the evidence to be submitted electronically.

Progress is therefore underway, with an agreed resource and time commitment to address compliance levels in 2023, and is being monitored by the Chief Executive, Director of Finance and eHealth, Head of eHealth, and IT Security Officer.

3.3 POST REVIEW

It should be noted that after the 2023 review and issue of the results therefrom, the Competent Authority who undertake the review will be arranging a meeting on site with the Non-Executive Directors to discuss the outcome. This date is still to be confirmed.

4 RECOMMENDATION

The Board is to note the report, the follow-up actions being taken forward, and that in-year progress will continue to be reported to future meetings.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	N/A
Workforce Implications	N/A
Financial Implications	N/A
Route to Board Which groups were involved in contributing to the paper and recommendations	eHealth subgroup, IGG CMT
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)	
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. 23/59

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 June 2023
Agenda Reference:	Item No: 27
Sponsoring Director:	Director of Security, Estates and Resilience
Author(s):	Head of Estates & Facilities
Title of Report:	Property and Asset Management Strategy Update Report
Purpose of Report:	For Noting

1 SITUATION

The Scottish Government Health Finance, Corporate Governance and Value Directorate has emailed Boards notifying them of the arrangements for the State of NHSScotland's Infrastructure (SAFR) programme and Property and Asset Management Strategy (PAMS) for 2023. No formal letter will be issued by Scottish Government about this year's programme.

For this year, the deadline set for the return of the SAFR pro forma templates is Friday 30 June 2023. In terms of PAMS the Scottish Government have advised that they are not seeking submission of NHS Boards' PAMS document this year, unless they specifically wish to engage with Government about their future investment ambitions.

2 BACKGROUND

The 2017 – 2022 PAMS was approved by the Board in June 2017 prior to submission to Scottish Government Health and Social Care Directorate.

3 ASSESSMENT

The SAFR pro forma templates will be completed and returned for Friday 30 June 2023. A PAMS report will be produced for internal approval in line with Scottish Government policy.

4 RECOMMENDATION

That the Board **notes** the content of this paper.

Paper No. 23/59
MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Support of PAMS policy for the Board
Workforce Implications	As detailed, no specific
Financial Implications	As per report
Route To Board Which groups were involved in contributing to the paper and recommendations.	To comply with Scottish Government request / Board Workplan
Risk Assessment (Outline any significant risks and associated mitigation)	As per report
Assessment of Impact on Stakeholder Experience	As per report – none identified
Equality Impact Assessment	N/A
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	N/A
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One √ There are no privacy implications. □ There are privacy implications, but full DPIA not needed □ There are privacy implications , full DPIA included.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 June 2023
Agenda Reference:	Item No: 28
Sponsoring Director:	Director of Security, Resilience and Estates
Author(s):	Programme Director
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 18th May 2023 and is scheduled to meet again on 20th July 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:

The project is in the final stages. All quality targets are being met; project timescales have moved (see Project Timescales at 3b below) and costs are projected to overspend (See Finance – Project Cost at point 3c below).

b) Project Timescales

Programme revision 48 has been accepted with Caveats. Delays in the camera commissioning have led to the movement of some dates and forecast completion is now 28 September 2023. The installation of technology is substantially complete, though some critical areas remain. Full completion of the main technological elements of the project (prior to commissioning and Site Acceptance Testing) is forecast for July.

c) Finance – Project cost

The project is proceeding according to the current projected cost plan, in that the contract with Securitas is due to underspend against budget and contingencies. Project management costs and associated contingencies have been affected by the project timescale resulting in a potential overspend (exclusive of VAT) of approximately £365k, 4% of the projected final cost.

The key project outline at 28th April is:

Project Start Date:	April 2020
Planned Completion Date:	September 2023
Contract Completion Date:	April 2022
Main Contractor:	Securitas Technology Limited
Lead Advisor:	Thomson Gray
Programme Director:	Doug Irwin
Total Project Cost Projection (Exc. VAT) at 28/05/23:	£9,156,736
Total costs to date (exc. VAT) at 28/05/23:	£8,457,360
Total costs to end of project (Exc. VAT, Inc. Retention)	£ 699,376

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.

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 (Exc. VAT) at end of April 2023 is below.

Securitas	£ 6.843m (5% retention applied)
Thomson Gray	£ 0.873m
Doig & Smith	£ 0.008m
HVM	£ 0.150m
Staff Costs	£ 0.668m
Income	-£ 0.084m
Total	**£ 8.457m** (Corrected for rounding)

VAT has been excluded from calculations of amounts paid due to the need for the reclaim to be applied for and assessed.

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.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 June 2023
Agenda Reference:	Item No: 29
Sponsoring Director:	Chief Executive Officer
Author(s):	Head of Communications
Title of Report:	Communications Service Update
Purpose of Report:	For Noting

1 SITUATION

The Board is seeking an update in respect of Communications resourcing / service delivery, digital transformation, and State Hospital branding. This update is provided as at 1 June 2023.

2 BACKGROUND

In 2022, the Board approved the appointment of two Communications posts:

- **PR & Media Communications Officer -** Specific emphasis being placed on raising the profile of the State Hospital by engaging and educating stakeholders through the daily management of social media channels and the creation of content.

- **PR & Digital Communications Officer –** Key areas of responsibility include the Website and Intranet.

Additional work was scoped to assess if an early rapid redesign of the website could be undertaken as a one-off project and priority for the Board.

The Board also expressed an interest in the redevelopment of the Intranet and State Hospital branding.

3 ASSESSMENT

Communications Resourcing

The two posts were advertised as an indicative Band 5 pending job evaluation. The Agenda for Change evaluation process is now complete with both posts being confirmed as a Band 5.

The PR & Media Communications Officer took up post on 3 October 2022. Following induction and Communications familiarisation, the post holder is now settling well into the role. Focus has been on developing our social media presence, producing staff bulletins, assisting with the implementation of the redesigned website, assisting with media enquiries, supporting identified groups / initiatives, and managing the three Communications email boxes.

The PR & Digital Communications Officer took up post on 5 May 2023. Focus is on completing the mandatory induction process which provides information about the Hospital, its policies and procedures, and relevant training. Concurrently, the post is undertaking in-depth Communications Service familiarisation training. This is two-fold, firstly to ensure understanding of how we do things in Communications and why, and secondly to explain / agree the expectations of the role. This is critical so new posts understand their responsibilities thoroughly before commencing their duties.

Role objectives have been agreed for both posts supporting the Board's vision and corporate objectives.

Communications Service Delivery

<u>Priorities – (February to end July 2023) – now complete</u>

- Deliver familiarisation training / support for the PR & Media Communications Officer including the setting of tasks / objectives / review.
- Recruit PR & Digital Communications Officer post.
- Review and update of the Communications Strategy and associated actions.
- Continue to support the implementation of the new Clinical Model through the delivery of the Clinical Model Communications and Engagement Plan.
- Enhance social media presence with the introduction of LinkedIn.

<u>Priorities – (February to end July 2023) – ongoing</u>

- Support recruitment and induction initiatives through social media and other channels to raise the profile of the State Hospital.
- Continue with work to support the Security Refresh Project through the delivery of the CCTV Implementation Communications Plan / community engagement.
- Undertake preparatory work for the introduction of the new Intranet site 'Sharepoint Online'.
- State Hospital branding.

<u>Priorities – (February to end July 2023) – on target</u>

- Review and update of State Hospital Corporate Document Standards.

Priorities – (August to December 2023)

- Develop specific social media campaigns that support key actions within the Communications Strategy Action Plan / raise the profile of the State Hospital.
- Review and update of the State Hospital General Presentation / speakers' directory.
- Develop Communication Asset Registers to ensure compliance with Records Management legislative requirements.
- Explore delivery of in-house video production. Also review of existing State Hospital videos on the State Hospital YouTube channel with a new to updating or removing.

Future Priorities

- Review of State Hospital publications and create a publications database.
- Review of State Hospital photos and create a photo library.
- Develop a bank of expert spokespeople.
- Explore a media monitoring service with an external company.
- Produce good news stories for local and national media as appropriate.
- Actively place features in psychiatric and nursing healthcare journals.
- Produce a suite of educational materials that can be used to raise the profile of the State Hospital externally.
- Review and update the State Hospital Wikipedia page.
- Explore social media for businesses and ensure two-factor authentication is enabled.
- Develop a bank of templates for social media posts, e.g. HR recruitment.
- Explore Twitter Grey Tick / Verified for Businesses.
- Explore Linktree as a means of driving traffic between social media platforms and increasing engagement.
- Explore Microsoft Sway for staff communications / publications.

The Communications Service remains committed to building capacity for the future, with an emphasis on appropriate resilience, succession planning and growth.

State Hospital Website – Project Complete

As previously reported, the website has been redesigned and launched. Feedback continues to be positive. The focus is now on a cycle of continuous improvement: maintain, develop, implement, monitor, and review.

State Hospital Intranet

Reminder!

Plans are underway to redevelop the State Hospital Intranet. The current Sharepoint Intranet site (now at end of life) is managed by eHealth. eHealth and Communications are working collaboratively to implement a new Intranet site (Sharepoint Online). When implemented, this will be adopted by Communications with corporate responsibility transferring from eHealth to Communications. Sharepoint Online is being led nationally for all Boards by National Services Scotland (NSS). The project is at an early stage nationally pending resources, governance approvals and other necessary requirements to ensure successful implementation across NHS Scotland.

Update!

A two-day workshop took place on 31 May and 1 June 2023 with eHealth and Communications in attendance. This provided an overview of what Sharepoint Online can offer. Pending national progress, work will commence at the end of July locally with Communications taking the lead on reviewing current content with content owners, agreeing what content will be migrated to the new site, and developing the design of the new site. This will help ensure local readiness for when we get the green light nationally to proceed.

A timescale for implementation for the State Hospital remains unknown; however, we could still be looking at 12-18 months from now.

eHealth and Communications are committed to working closely together to ensure implementation of Sharepoint Online is done effectively and quickly when the time comes.

Meantime, the current Intranet site continues to be live and content updated.

NHS Scotland National Branding

Reminder!

The Scottish Government is reviewing the NHS Scotland national branding. This provided an opportunity for the State Hospital to put a case forward for a State Hospital variant of the NHS Scotland logo that more clearly identifies the State Hospital as an NHS Scotland organisation. Branding includes both logo and name. All NHS organisations within the family use NHS in their name and so any change is likely to mean that our name would change to NHS State Hospital and NHS State Hospitals Board for Scotland as appropriate. A business case has been submitted to the Scottish Government. The process will take a few months to complete, and we are confident our business case will be successful.

Update!

The process is taking longer than anticipated. We acknowledge recent ministerial changes with a new Cabinet Secretary and Minister for Mental Health, and with this comes other priorities for the Cabinet. We continue to be patient.

4 RECOMMENDATION

The Board is asked to note the update.

MONITORING FORM

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

THE STATE HOSPITALS BOARD FOR SCOTLAND

AUDIT AND RISK COMMITTEE

Minutes of the meeting of the Audit Committee held on Thursday 6th April 2023.

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

Chair:	
Non-Executive Director	David McConnell
Present:	
Non-Executive Director	Stuart Currie
Employee Director	Allan Connor
Non-Executive Director	Pam Radage
In Attendance:	
External Auditor, KPMG	John Blewett
Internal Auditor, RSMUK	Victoria Gould
Chief Executive	Gary Jenkins
Internal Auditor, RSMUK	Asam Hussain
Director of Nursing and Operations	Karen McCaffrey (item 7)
Director of Workforce	Linda McGovern (Items 7 and 12)
Director of Finance and eHealth	Robin McNaught
Board Chair	Brian Moore
Head of Corporate Governance	Margaret Smith
Director of Security, Estates, and Resilience	David Walker

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

Mr McConnell welcomed everyone to the meeting, and no apologies were noted.

Members were advised that the meeting would be recorded for the purpose of minute taking and it was confirmed that the recording to be deleted once minutes taken

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 26th January 2023 were noted to be an accurate record of the meeting with exception a point reflected in the last paragraph of page 5, Ms Radage noted an error regarding a comment attributed to Mr Currie was in fact made by Mr McConnell, Ms Smith would make the necessary adjustment to rectify this.

The Committee:

1. Approved the minutes of the meeting held on 26th January 2023 once the aforementioned amendment is in place.
2. Approved the separate minute of item 20 relating to Internal Audit services.

4 MATTERS ARISING – ACTION PLAN UPDATE

There were no additional urgent matters which arose for discussion.

5 Action List: Updates

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

Members were content to note all actions as complete and closed.

The Committee:

1. Noted the updated action list.
2. Mr Walker informed the committee that Ms McGovern has taken forward the actions in relation to Risk HRD111 through a short life working. This will then be reported to the Board on 27th April with a formal update on what control measures are in place and a review of the risk.
3. It was noted that Item 5 relating to the NIS audit had been remitted to the Board taking place this month.

INTERNAL AUDIT

6 (a) Audit Progress Report

Mr Asam Hussain from RSMUK provided an overall progress update on the Audit Progress Report and stated that since last the meeting the auditors had issued three of the four previous audit reports, these are in the areas of Workforce and Rostering, Incident Management and Performance Management. The Payroll Report is in progress and will be shared once finalised. Auditors will continue to track performance against audit actions. The auditors were on track to deliver the plan and the opinion on good time for the committee to inform the annual governance statement.

b) Tracking Report

Mr Hussain advised that there are nine actions on the tracker, three eHealth actions remain untracked, these would be implemented by the end of April. 3 actions from the clinical observations report have been extended to 31st July and three actions from the financial control audit are being embedded as part of the year end process. It was noted that these will be concluded soon and removed from tracker once completed.

(c) Using Your Strategic Risk Appetite

Mr Hussain presented to the committee a Risk Appetite Paper from RMSUK risk advisory colleagues which is available for information. Mr McConnell thanked Mr Hussain stating he found this paper to be interesting and useful.

Mr Jenkins also thanked Mr Hussain and found the paper to be interesting and helpful and further stated that it gives a good framework that could be applied to the way the organisation considers risk. Mr Moore welcomed this information stating he found this to be a helpful addition to be considered further by the Board.

The Committee:

1. Noted the reported updates by RSMUK.

7 AUDIT REPORTS

(a) Workforce Planning and Rostering

Mr Hussain provided a progress report on The Workforce and Rostering report which had resulted in a 'partial assurance' outcome, generating 3 high, 2 medium and 1 low priority action points. Mr Hussain discussed these action points in detail. The key findings of each action point were also considered in detail, as well as the planned actions.

Mr McConnell thanked for Mr Hussain for the overview then invited questions from the committee.

In answer to a point raised in the report that stake holders were not involved in the development of the 3 year workforce plan, Ms McGovern agreed that that is a learning point, particularly relating to discussions that take place with key stakeholders. In terms of the plan moving forward this does form part of the Workforce Governance Group, and these actions will be updated accordingly, Ms McGovern also agreed to review the workforce plan around completed actions and those areas that required further focus.

Ms McCaffrey further noted in relation to the workforce aspect of the report that there are no suitable workload tools available at present for a high security environment. Ms McCaffrey made reference to previous reporting in this respect in relation to the staffing resource that is allocated as part of the clinical model, in the absence of bespoke work load tools. The methods used included bench marking against the other high secure services in England and Ireland. This is a process that the Hospital is continuing to engage in. Ms McCaffrey further outlined work in relation to the introduction of eRostering, the Supplementary Staffing Roster, as well as introducing a new ready reckoner that is used in other health boards. This will enable the staff to recognise the most cost effective approach to filling shift deficits. Ms McCaffrey acknowledged that the requirement to fill ward deficits sits centrally and that in order to move this process to the wards for our Senior Charge Nurses to undertake this task we have to identify what training needs to be put in place for this cohort of staff.

Mr Currie acknowledged the report and stated that this has completed the remit by highlighting the areas to work on. He felt a positive note is that the report has highlighted areas that already have work ongoing. He agreed with the report and the other committee members that in future it is important that a robust audit trail is in place and to ensure that knowledge and expertise does not get lost. Mr Currie noted the importance of sign off by the Board prior to submission to Scottish Government for key strategies.

Mr Connor noted that on page 18 of report it states that hospital does not have any formal protocol in place for around staff annual leave, noting the annual leave protocol in place for Nursing and Skye Centre staff.

Mr McConnell queried where does the eRostering project fit into some of the action points that were raised within the report. Ms McGovern gave some background on the system saying that this has all the information regarding establishment per department, the system also holds all absence information. Each area will be able to view their budget in terms of staffing and this also allows staff to view their own shifts and apply for any vacant shifts via the staff online system. Lead Nurses will be able to see the staffing picture as a whole rather than individually per hub. Mr Hussain added that the eRoster system has an audit trail all in one place, one key feature of the system is the visibility to allow movement of staff where there are peaks and troughs before we start to think about overtime.

Mr Jenkins thanked Mr Hussain and the team at RSMUK for the report, and confirmed that the Corporate Management Team would take oversight of progress of the actions. In a further addition to Mr McConnell's query regarding eRoster Mr Jenkins informed the meeting that there is a benefit realisation paper due to be finalised by 14 April which will show us what components of eRostering link across to some of the required actions. To further answer some of the points raised within the report Mr Jenkins stated that the CMT had remitted organisational leadership to a central Workforce Governance Group to ensure focus, with an agreed remit and set of responsibilities.

In addition Mr Hussain also added that RSMUK liaised with Ms McCaffrey and Ms McGovern when setting timescales for actions to allow us to be as realistic as possible.

Mr McConnell further thanked Mr Hussain and RSMUK for the report he also thanked members of the committee for all comments and contributions. Mr McConnell concurred with earlier statements that dates for completion are of great importance and that the committee will continue to monitor this. He added that since this is a 'below the line' report reference to this will be made in the annual governance statement.

Action – Mr McNaught

(b) Data Quality - Performance Management
Mr Hussain provided an overview of the Data Quality Report and informed the committee in detail which areas this report looked into. In conclusion this was a reasonable assurance opinion, there were three medium and two low priory actions agreed. The concluding remarks were that whilst the Board has an established control framework in place for monitoring and reporting KPI's and there is further work required to ensure consistency in reporting and the data collation was done efficiently. Further work was required in terms of documenting the robustness of the challenge and scrutiny and remedial actions through the governance structures. Mr Hussain also explained the five action points in detail.

Ms Merson thanked Mr Hussain and team for audit. Ms Merson appreciated the scrutiny of the of our processes and learning from it. Ms Merson felt that the report highlights the importance of governance in our processes and to be able to provide an auditable trail.

Ms Merson further added that the use of data in reporting has improved greatly within TSH especially the development of the performance framework, the operational definitions for KPI's, having a regular strategic planning performance meeting. She noted that Director performance meetings showed evidence of review of performance at all levels. Ms Merson felt the report was helpful in seeing all these processes coming together, to highlight the importance of automated data wherever possible, as this takes away where possible the reliance on individuals and the issue of corporate memory being lost if people move on from the organisation. Lastly, Ms Merson agreed that all actions will be addressed by the agreed dates.

Mr Jenkins welcomed the report stating he felt it was helpful and timely, it will enable Ms Merson and Mr Jenkins and other colleagues to make sure the alignment was correct. Mr Jenkins added that TSH is currently looking to further develop the management performance framework as had been outlined by Ms Merson, and stated that this report is helpful to allow the members to tidy up on some of these components that sit within these. Mr Jenkins further acknowledged that we have come a long way in terms of digital development and we should reap the benefits of this in the coming 6 to 12 months.

Mr Currie thanked Mr Hussain for the report and the members for comments. Mr Currie welcomed the fact that there are no high priority actions. He further stated that automation of data is also beneficial in how to find out where issues have occurred rather than manual entry into spreadsheets. Lastly Mr Currie expressed the feeling that credit should to be given to staff for progress already achieved in this area of the report

Mc McConnell concurred with the statement made by Mr Currie.

(c) Incident Management
Mr Hussain fedback to the committee the findings of the Incident Management Report. Mr Hussain provided the meeting with an overview of the report and in-depth information in relation to the outcome, the report was undertaken to provide assurance that there was a framework in place for managing and escalating incidents in line with Scottish Government requirements.

Mr Hussain informed the committee that the auditors conclusion was a positive 'reasonable assurance opinion' with only two medium priority actions. The conclusion reached by the auditors was that the framework in place for managing and escalating incidents within the hospital is adequate and in line to requirements of Scottish Government, there were areas for enhancements which Mr Hussain discussed with the committee along with an in-depth look at the two medium priority actions

Mr McConnell thanked Mr Hussain stating he felt the report was very useful.

Mr Walker advised that the Risk Management team were working on the points raised and feeding back on the report. Mr Walker welcomed that we were following the national guidance on adverse event reviews. Mr Walker further added that The Risk Management team is a very small team and

there are ongoing talks to realign resources to provide more support to this team to ensure we have a more effective department to allow them to look at where there are trends and to provide analysis.

Mr Jenkins noted the challenge for us with a small albeit very good risk management team is to ensure the data in Datix is accurate and that we are minimising the risk of multiple people reporting on the same incident. He further added that there is a redevelopment of an operational policy which is near completion and this will enable more consistency in incident recording and reporting.

The Committee:

1. Noted the Audit Reports by RSMUK
2. Agreed that the Annual Governance Statement should reflect reporting.

8 Draft Internal Audit Plan 2023/24

Mr Hussain informed the committee that there were four key areas, two of which had been carried forward from previous years. One of these relating to the review of the implementation of the clinical model; and the second was the security review. There were two new areas, one being around environment of social governance, where we look to review how the board has implemented and adopted the policy from NHS Scotland on the Climate, Emergency and Sustainability development, auditors will sample test some of these. The other review is around patient monies where they will focus on the implementation of the new patient monies system and how that is operating in practice.

Mr Jenkins thanked Mr Hussain and team at RSMUK for the plan. Mr Jenkins concurred with all points however would like to provide feedback on some wording within the report. In terms of security review which should refer to the upgrade to the existing fence, rather than a new fence.

Action – RSMUK

Mr McConnell agreed with Mr Jenkins for the need to modify some of the wording used and stated that there will be ample opportunity over the coming year to make any necessary adjustments. Mr McConnell welcomed the plan commenting that it focuses on the correct areas and again thanked Mr Hussain.

The Committee:

1. Noted the update by RSMUK.

INTERNAL CONTROL AND CORPORATE GOVERNANCE

9 Risk Strategy

Mr Walker presented the Risk Strategy paper to the committee and noted the requirement for the organisation to review the risk strategy paper every three years. Mr Walker provided a summary and referred to the bullet points within Section 2 and asked for any comments from the committee to ensure these bullet points reflect accurately what is required.

Mr Walker further explained that a number of changes have been made to the risk management strategy and that these have been fed through the Board and Audit Committee as well as development sessions. Changes include updating of groups to reflect the current hospital management and structure, departmental roles have been updated to reflect the current hierarchy. The risk matrix has also been updated. Mr Walker asked the committee for any feedback and approval of this paper.

Mr Moore Thanked Mr Walker and referred to page 14 of the paper asking that in relation to the responsibility of standing committee's to have oversight of some of the risks that fall within their remit if this could be more explicit on the grid under 3.1. Mr Walker agreed with Mr Moore and will update this point.

Action – Mr Walker

Mr McConnell thanked for Mr Walker this useful overarching report further commenting he felt it would be very useful going forward.

The Committee:

1. Approved the Risk Strategy

10 Corporate Risk Register

Mr Walker presented an update to the Corporate Risk Register since last committee meeting, giving an overview on any outstanding Risks. He also informed the committee that there are no new proposed risks for inclusion in the Risk Register. And summarised the updates to existing risks within the register. Lastly Mr Walker referred to the current four high Risks contained within the paper stating that these continue to be monitored. With reference to the particular risk of HRD 111 Deliberate Leaks of Information, Mr Walker informed the committee that this has been discussed at CMT and the Director of Workforce would provide a further update for the Board this month.

Mr Currie referenced the work undertaken at the Board Development Session in January 2023, asking that a reflection of this could be included in future reporting. Mr Walker answered this point by acknowledging changes in organisational thinking since the Covid 19 pandemic. Mr Walker added that the documents provided by Mr Hussain and the RSMUK team are helpful in achieving this. Going forward Mr Walker would like to formally incorporate this into the risk management strategy. Mr Walker ended the point by saying that to achieve this we would need to formally agree our risk appetite then look at the corporate objectives and how they align to new approaches that we will adopt. Mr Currie thanked Mr Walker and agreed, adding that this will be a good discussion to continue in due course.

Mr Jenkins agreed with Mr Walker and recognised that as we develop this further we will make tailored amendments to the risk strategy as a continuing work in progress.

Mr McConnell asked a question on a point regarding the Impact to Covid 19 Inquiries, whether the TSH approach is in step with other organisations. Mr Jenkins answered Mr McConnell by saying we now have a dedicated resource in place whilst recognising that there will be peaks and troughs in this workstream going forward. Ms Smith concurred with Mr Jenkins stating that we never had any direct involvement as a Board with Public Inquiries; and so had started with a standing point of high risk in terms of resourcing until resources were put in place.

Ms Radage asked for clarification surrounding the decision from the short life working group on the risk of Deliberate Leaks of Information, and whether this meant shifting the discussion with staff to PDR meetings rather than to all staff more generally Mr Jenkins advised this output was due shortly to the Corporate Management Team and an update would come to the Board.

Mr McConnell thanked Mr Walker for his presentations and the committee for their comments.

The Committee:

1. Approved the Corporate Risk Register, with no amendments suggested.

11 Adverse Events Action Tracker

Mr Walker introduced the Adverse Events Action Tracker by saying that it links into the review of incident management of any adverse events. Mr Walker further stated that there is a risk to the organisation if we do not pick up on the recommendations from these and review and implement them.

Mr Walker advised the committee that The Security Risk and Resilience Oversight Group provide an overview on the progress of CAT 1 and CAT 2 investigations and in addition they are monitored through the Organisational Management Team.

As some of these issues have been outstanding for some time Mr Walker gave the committee a brief overview of what these involved and informed of any relevant updates. This included Estates work on fixtures and fittings, which required costings and may impact on the 2023/24 capital budget. Mr Walker also wanted to clarify the point that we do currently have Loggists trained and they are on call 24 hours per day throughout the entire year. Further he confirmed work was progressing on the action relating to the SRK policy.

Lastly Mr Walker highlighted current review of the policy around patient use of the telephone, to enhance the ability to record phone calls. This was being taken forward with benchmarking practice to other high secure hospitals.

Mr McConnell thanked you Mr Walker adding this had been very useful and that the paper is noted, with no further questions .

The Committee:

1. Noted the Update on adverse events Tracker

12 Attendance Management – Risk Report

Ms McGovern gave an update on sickness absence which was detailed within the report. Current absence levels are having an impact in resources in regards to excess hours and overtime , this has being analysed through the Workforce Government Group to ensure that all that can be done is being done. Ms McGovern informed the committee that information is being analysed going back as far as 2019 in relation to absence. There has also been an assistant HR Advisor made available to aid managers with attendance management and to give advice.

As part of the update Ms McGovern informed the committee that work is progressing on analysing absence and highlighting issues, also identifying any training needs that line managers may require to enable them to have difficult conversations with staff regarding absence and returning to work. Ms McGovern further explained the benefits of the new eRostering system by explaining that this can look at patterns in absence by individual staff members.

In addition Ms McGovern informed the committee that the Wellbeing Team are currently providing outreach support to the hubs which has been very successful with a 2nd round of their initiative, Coffee, Cake and Conversation, due to start. These sessions are being well attended with Senior Charge Nurses and Charge Nurses freeing up time to allow staff to attend. The Wellbeing Team report this is a benefit to them and to the staff attending these sessions. Lastly, Ms McGovern made the committee aware that as of 1st April 2023 we have a new Occupational Health Team. The team held a meet and greet session in the Wellbeing Centre which was well attended.

Mr Jenkins wished to add some more context stating that through the Performance Review Meeting a 2% improvement plan was set in December 2022. Mr Jenkins agreed that some areas needed improvement and that focused work is ongoing. Mr Jenkins hoped this showed more granularity in relation to some of the direct actions in the performance review components of the report regarding the management of attendance.

Mr Moore commented that it very useful and helpful to see the financial impact and cost implications of absence contained within the report.

Mr McConnell thanked Ms McGovern stating that report was noted along with the assurances given.

The Committee:

1. Noted the Attendance Management – Risk Report

13 Policy Update

Mr McNaught introduced the policy update by stating that the paper provides an update on policy reviews showing a slight light up turn on previous trend , which can be attributed to the time of the conversion of some policies to guidance. This is something that is being closely monitored. Mr McNaught added that the policy approval group continues to lead on the approvals for the policies coming through and to consider appropriate extensions when required and should be noted that the Once for Scotland policy review continues to have a considerable impact on the HR policies.

Ms Radage asked if there were lessons to be learned across TSH especially on whether policy or guidance documents were appropriate. Ms Radage also enquired about the number of policies past their review date, currently at 15. Mr McNaught answered that policy reviewers are aware of what has been achieved elsewhere and have taken guidance across other directorates however, they need to be mindful that each policy has to be taken on its own context to ensure the correct criteria are met. In answer to the second question Mr McNaught added that the number of policies past review date should sit at 10 or below.

Mr McConnell thanked Mr McNaught adding that the report shows this is relatively steady and noted the assurances given.

The Committee:

1. Noted the Policy Update.

14 Fraud Update and Action Plan

Mr McNaught delivered an overview of the Fraud update and Action Plan stating that the paper combines both the fraud update and action plan adding that some of the points raised at the last meeting have been reviewed and those point addressed within this update. Mr McNaught continued that the data matching exercise is nearly complete and that no issues of concern have been highlighted to date.

Mr McNaught was pleased to report that in the last quarter there were no referrals to the Counter Fraud Service regarding issues within The State Hospital. Lastly Mr McNaught stated that The Counter Fraud Service virtual sessions continue to be circulated and that the number of alerts issued since the last report are continuing to be reviewed and circulated as appropriate within the hospital, to ensure that all newly reported approaches are noted and appropriate directorates are alerted.

Mr Currie made the committee aware that he had recently attended a national meeting in his role as counter fraud champion, something that may be useful in getting the message across to push the profile of counter fraud across TSH.

Mr Connell thanked Both Mr McNaught and Mr Currie and added that the report was noted.

The Committee:

1. Noted the Fraud Update and Action Plan

15 Cyber Security Report

Mr McNaught was pleased to report to committee that no national or local specific risks in last quarter in relation to cyber security, adding that there continued to be strong awareness of risks and circulated alerts when they do arise. Mr McNaught commented that since paper was put forward to the committee a full upgrade over of back up system was completed over one weekend, so this is now fully up to spec with latest version, adding a full test is to be held soon.

Mr McNaught informed the committee that he had attended a National Cyber Awareness Course and will ensure continue to be part of any national discussions that are ongoing. Lastly Mr McNaught added that cyber security training continues through management requirements.

Mr McConnell thanked Mr McNaught and noted the report.

The Committee:

1. Noted the Cyber Security Report

EXTERNAL AUDIT

16 Interim Audit Update 2022/23

Mr John Blewett from KPMG discussed their draft Audit of Financial Statements starting off by giving a brief update on the interim audit work saying that the risk assessment work has been done and a draft of the plan should be issued by the end of the week. Mr Blewett informed the committee KPMG had been on site at The State Hospital to meet relevant staff and that they hope to repeat this at the final stages. Finally Mr Blewett stated that KPMG are making good progress with the final stage due for May 2023.

Mr McConnell Thanked Mr Blewett for this overview enquiring if KPMG would normally produce an interim report.

Mr Blewett replied saying that they would not normally unless for any significant reasons and explained the rationale for this.

The Committee:

1. Noted the Interim Audit Update 2022/23

17 Audit Plan 2023/24

Mr Blewett then discussed with the committee the Annual Audit Plan explaining KPMG's reporting thresholds which are mandated areas are as directed by Audit Scotland. Mr Blewett drew the committee's focus to page 192 of the audit pack which outline the significant risks, explaining each of these risks and reasoning surrounding these areas.

Mr Blewett continued with an overview of the draft audit highlighting pages for the committee's benefit with brief discussions of each, he then discussed the wider scope by stating that there are six areas for KPMG to look at which are mandated by Audit Scotland providing an update on the status of each – and confirming no issues had been identified to date.

Mr Jenkins referenced audit summary and a point regarding Audit Scotland's planning guidance asking if this will be a new requirement going forward or is this a standard requirement. Mr Blewett confirmed that this related more to general guidance about arrangements.

Mr McConnell queried in reference to Cyber Security would KPMG use reviews from NIS and ICO as a source. Mr Blewett agreed adding that in terms of risk, the NHS continues to be a risk so making sure this is high on the agenda. Mr Blewett ended the update of the Annual Audit Plan.

Mr McConnell thanked Mr Blewett reiterating to the committee that this is a draft and as such there may be some finalising still to be done and this will also include a possible change in the required fee. Mr Currie reflected on the need for flexibility with the plan in case of future external or other factors. Mr Blewett answered this by saying that the audit teams are aware of issues and the changes that can affect this adding that they generally know ahead of time of changes that may have an impact.

Mr McConnell thanked Mr Blewett for assurance given and asked if the committee has the opportunity to see a final version of the report or if there has been any updates.

Mr McNaught answered this point by saying that if there are any changes it can be circulated to the committee adding however, that there are no changes expected.

The Committee:

1. Noted the Audit Plan 2023/24

NATIONAL REPORTS

18 NHS in Scotland 2022

Mr McNaught discussed the NHS Scotland 2022 report giving highlights from the report which included the four key recommendation areas – Financial Pressure, Workforce, Recovery Plans, Transparency.

Mr McNaught also wished to highlight the specific action points noted within the report, noting there are two that have relevance to the TSH. These action points are Staff retention and Collaborative working. Mr McNaught added that there was an additional report published – Scotland's Financial Response to Covid 19 Spending Update, which was a follow up the report issued last year and he urged committee to have a look at this particular report.

Mr McConnell thanked Mr McNaught and agreed saying that this was an important report for committee to peruse if they are so able.

The Committee:

1. Noted NHS in Scotland 2022 Report.

STANDING DOCUMENTATION / GOVERNANCE STATEMENT

19 Draft Governance Statement

Mr McNaught explained that this forms part of the yearly report on accounts adding that in relation to Covid 19 our governance structure remained in place fully throughout the last year.

Mr McNaught informed the committee that the wording of the internal audit and national audit referencing will be updated once finalised ,the internal audit referencing currently reflects the report and outcomes brought to today's meeting with specific reference to the high level actions that have been identified. Mr McNaught reminded the committee that this is a draft statement which could see any updates applied between now and year end finalisation.

Mr Moore welcomed the emphasis on the information risk , and asked that in reference to the recovery from Covid 19 is there a prospect of focusing on anticipating future issues.

Mr McConnell remarked that it is useful to have this information at this stage separately rather than in the Annual Accounts Report.

The Committee:

1. Approved the Draft Governance Statement

20 Review of Scheme of Delegation and Standing Financial Instructions

Mr McNaught delivered an update stating that these are for audit committee approval then to the board for approval and final adoption. Mr McNaught informed the committee that within the standing documentation there are no highlighted changes, He added that a detailed check has been carried out and that this document is up to date. Mr McNaught added that any changes that have been made have been minor explaining that these were in relation to job title updates. Mr Lastly Mr McNaught reminded the committee that these are live documents and can be subject to update at any time.

It was noted that the issue of the Board "seal" had been established and that reference to this could be removed.

Action – Mr McNaught.

The Committee:

1. Approved the Review of Scheme of Delegation and Standing Financial Instructions and recommended to The Board

21 Review of Accounting Policies

Mr McNaught delivered an update stating that these are for audit committee approval then to the Board for approval and final adoption. Mr McNaught highlighted one point within the policy to the committee in relation to the land and property indexation and added that there were no further points to highlight.

Mr McConnell stated that he and the committee are happy to approve policy as attached

The Committee:

1. Approved the Review of Accounting Policies for recommendation to The Board

22 Review of Board Standing Orders and Code of Conduct

Ms Smith brought Review of Board Standing Orders and Code of Conduct to the committee for approval stating that is was the annual review and is in line with national guidance. Ms Smith added that there no proposed changes .

The Committee:

1. Approved the Review of Board Standing Orders and Code of Conduct for recommendation to The Board

23 Review of Committee Terms of Reference

Ms Smith asked the board for approval of the Review of Committee Terms of Reference stating that there were minor amendments to terms of reference detailing each point. The main recommendation was the change of the name of the committee to be “Audit and Risk” to reflect its remit more accurately. Further, that attendance of members should form part of the annual report from this committee. Ms Smith added that this will be contained to each of the governance committee reports.

There was discussion around whether the committee chair should be the Board Vice Chair, and it was noted that there was variation on practice across NHS Boards, so this should be omitted.

Action – Ms Smith

The Committee:

1. Approved the updated terms of reference subject to change as discussed.

UPDATES FOR INFORMATION INTERNAL

24 Security, Resilience, Health and Safety Oversight Group Update

The update paper was noted.

The Committee:

1. Noted the update.

25 Finance, eHealth and Audit Group Update

The update paper was noted.

The Committee:

1. Noted the update

26 Any issues arising to be shared: Governance Committees

The committee agreed that internal audit reporting should be routed through future staff and clinical governance committees, to reflect the audit findings as well as progress on actions throughout this year.

Action – Secretariat

27 Any Other Business

There was no further competent business raised for discussion at this meeting.

28 Date and Time of next meeting

The next meeting will take place on Thursday 22 June 2023 at 9.45am via MS Teams.

End of meeting 1255 hours.