THE STATE HOSPITALS BOARD FOR SCOTLAND

PHYSICAL HEALTH STEERING GROUP
12 MONTHLY UPDATE REPORT

1 October 2021 – 30 September 2022

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Approval Group	Clinical Governance Committee
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1. Introduction

The State Hospital continues to recognise the importance of health improvement and disease prevention programmes that target the main causes of morbidity and premature mortality with particular attention to obesity and reducing cardiovascular risk and recognises that physical activity is an extremely important part of overall physical healthcare.

The Physical Health Steering Group (PHSG) governs food, fluid and nutritional care, weight management, physical activity and physical health services on behalf of the State Hospitals Board for Scotland.

The information within this report is taken from the reports which are presented to the PHSG.

2. Summary of Core Activity for the last 12 months

The following statistical information has been recorded during the period 1st August 2021 to 31st July 2022 and highlights the continuity of patient care provided by Health Centre staff throughout the COVID pandemic and the recovery from same.

Seasonal Influenza Vaccination Programme uptake for 2021/2022
There has been a percentage increase in patients accepting flu vaccination from 66.6% to 74.4%. There were 34 patients who fell into the additional "at risk" group, of this 27 (79.5%) patients consented to flu vaccination which is an increase from last year.

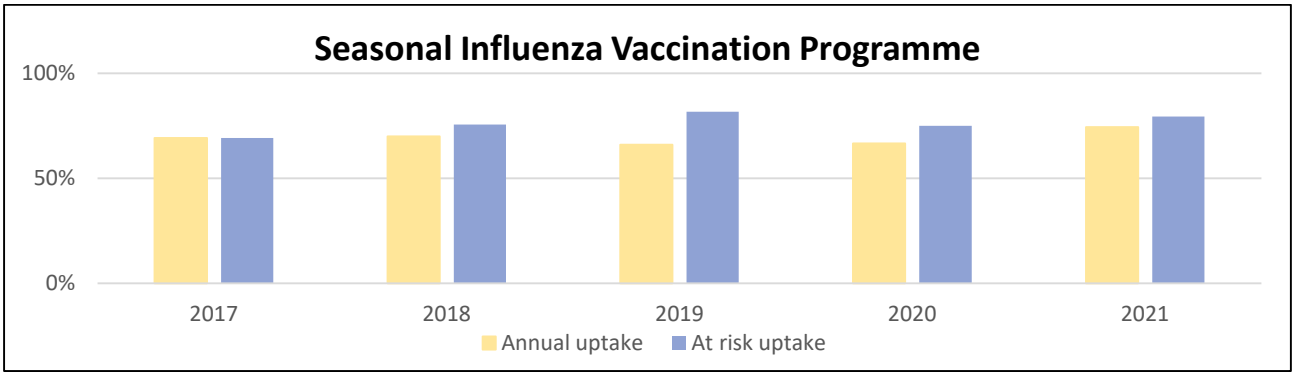
Table 1: Annual uptake - trend data for the last 5 years

2017		2018		2019		2020		2021	
77	69.3%	77	70.0%	70	66.0%	76	66.6%	87	74.4%

Table 2: At Risk uptake - trend data for the last 5 years

2017		2018		2019		2020		2021	
27	69.2%	28	75.6%	27	81.8%	24	75.0%	27	79.5%

Chart 1



Colorectal Screening
Bowel screening is offered to people aged 50 to 74 years across Scotland to help find bowel cancer early, when it can often be cured. Health Centre staff ensure bowel screening packs are sent to wards and that patients are encouraged to complete same. Currently there are 21 patients identified in TSH as aged 50-74 years. In the previous 2 years there were 24 patients offered screening with 11 patients refusing to participate.

Abdominal Aortic Aneurysm Screening
Men across Scotland in their 65th year are invited to be screened for Abdominal Aortic Aneurysm (AAA). This involves patients attending an outpatient appointment for an ultrasound scan. We currently have 2 patients over the age of 65 who are eligible for AAA screening; one patient has attended for this and one patient has refused.

Cardiovascular Risk Assessment

- August 2022 - within the hospital there are no patients with confirmed Coronary Heart Disease (CHD). We have 8 patients with hypertension (7%).
- August 2022 - 22 patients (19.5%) continue on Statin lipid lowering therapy to support reduction in cardiovascular risk.

Table 3: Trend data for last 3 years

Cardiovascular Risk Assessment	2020	2021	2022
Coronary Heart Disease	1 (0.87%)	0	0
Hypertension	8 (7.0%)	6 (5.1%)	8 (7.0%)
Patients on Statins/Fibrates	29 (32.8%)	25 (21.3%)	22 (19.5%)

Urinalysis Screen

All patients should have a urinalysis carried out by ward staff prior to their Annual Health Reviews. Urinalysis is requested with the annual health review questionnaire, if it is not obtained at this point a follow-up system is in place to ensure all patients provide same. As at the date of the report the Health Centre were awaiting ward staff submitting the urinalysis for the 3 patients referenced below.This screening has now completed.

Table 4: Trend data for the last 3 years

Urinalysis Screen	2019/2020	2020/2021	2021/2022
Screening completed	19	106	119
Screening outstanding	96	11	3

Diabetes

In August 2022 there are 9 patients (8.85%) with Type II Diabetes and one patient with Type I Diabetes.

Table 5: Trend data for the last 3 years

2020	2021	2022
11.40%	10.25%	8.85%

The Diabetic Retinopathy nursing team attend The State Hospital once per year to carry out annual screening to check for any signs of diabetic retinopathy. Seven patients attended for retinopathy screening, 2 patients refused to attend and 1 patient was physically unwell and unable to attend. This patient will be seen by the regular optitian (as per diabetic screening) when their health improves and any concerns will be communicated to the Opthamlolgy/Retinopathy specialist.

Annual Diabetic Foot Screening is carried out by our podiatrist. Five patients have attended for an annual foot review, 4 patients are outstanding and due to be seen in the next few weeks and 1 patient is too unwell to attend.

Respiratory Disease, Asthma and COPD

There is currently 1 patient with Emphysema, 10 patients with a diagnosis and 1 patient querying a diagnosis of Asthma and 2 patients with a diagnosis of COPD.

All patients are reviewed by the practice nurse dependent on their symptoms, i.e. 3 monthly, 6 monthly or yearly. A13ny flare ups are seen by the practice nurse in the first instance and then followed up by the GP.

Annual Health Review

Annual Health Reviews (AHR) have commenced again in the past year after the pause during the COVID pandemic. All patients are offered an AHR with the General Practitioner, this is timed in conjunction with the patient CPA to ensure the most up-to-date physical health information is available.

The AHR process includes blood monitoring, ECG, blood pressure, practice nurse review and face to face appointment with the GP. This allows early identification of various health issues, e.g. raised cholesterol, renal disease, liver disease, diabetes, inflammatory disease, among many others.

The following table illustrates AHRs carried out since commencement of our new GP in April 2022.

Table 6

Annual Health Review	April-July 2022
Eligible for AHR	35
Practice Nurse Review	35
Face to face with GP	34
Refused face to face with GP	1

Clozapine Monitoring Clinic

The Health Centre, in conjunction with Pharmacy, provides monitoring and support for the 40 patients (35.4%) on Clozapine (Aug 2022). Patients have the opportunity to discuss any concerns with the pharmacy technician, have their BP and pulse monitored, identifying patients with raised heart rates and BP potentially due to medication. This ensures patient's physical health is monitored and recorded as per national guidelines for anti-psychotic therapy**.**

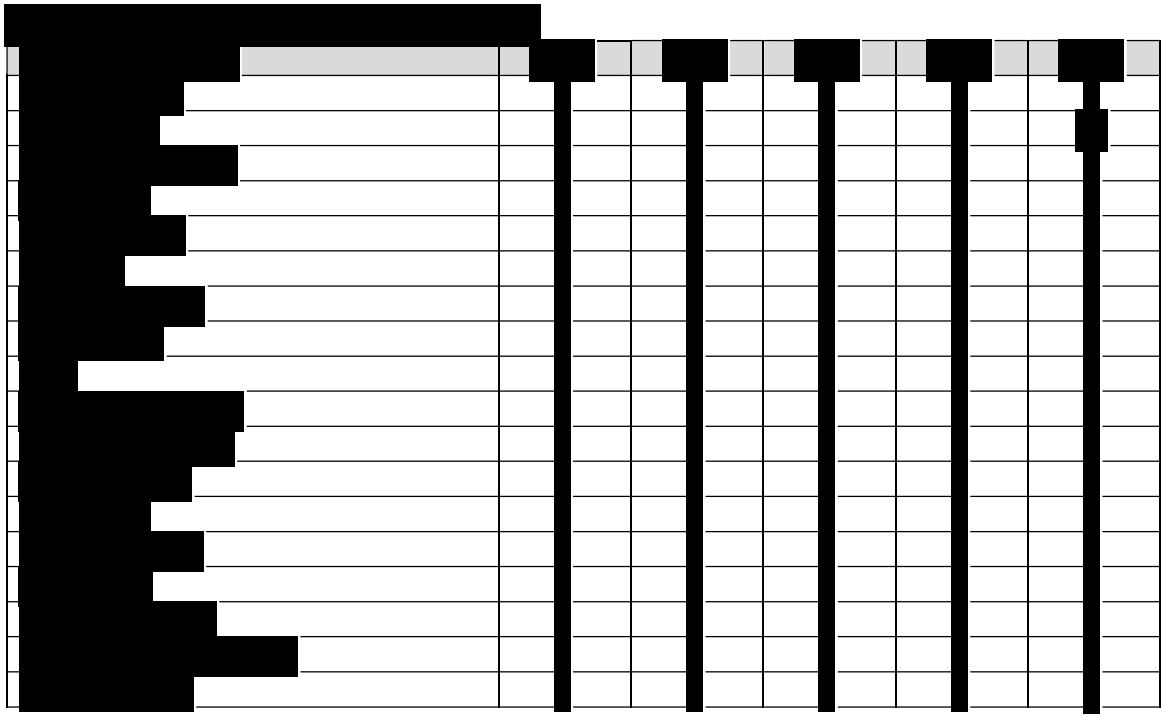
Contracted Services

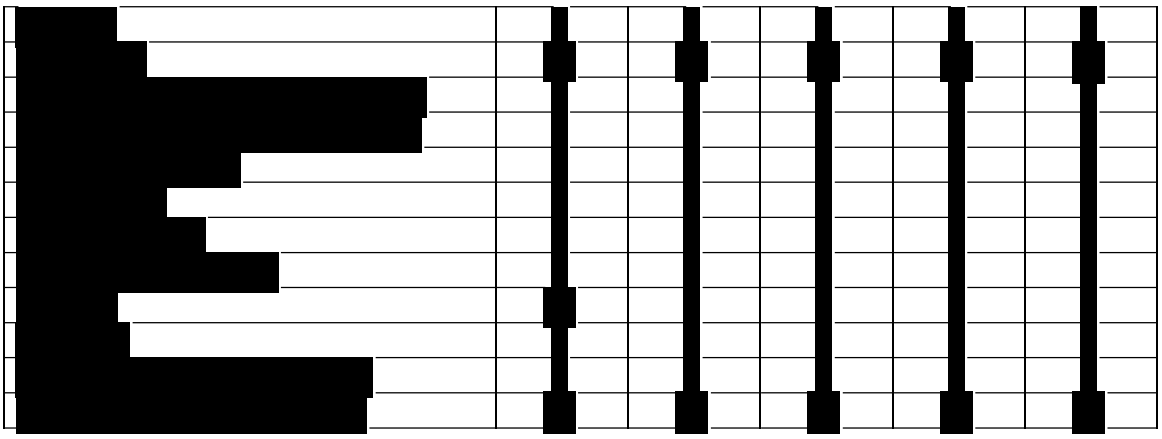
The hospital continues to have Service Level Agreements (SLA) in place for GP, Podiatry, Dental, Physiotherapy and Optician services.

Dr Ross Stewart has procured the SLA for GP provision since April 2022 and provides sessions on a twice weekly basis on Monday afternoon and Friday morning. The GP has commenced venesection on 2 patients, this has significantly reduced external clinical outings for treatment of same (a minimum of 1 outing per week over 16 weeks). The GP will also provide minor surgery on the patient group within the hospital, which again will reduce the need for external clinical outings.

External Referrals for Specialist Review by GP, Dental Service and Clinical Team

Table below shows a total of 73 referrals were processed for 47 patients. During this period, it was the Advanced Nurse Pratitioners who mainly reviewed the patients and generate referrals in the absence of a GP. Upon appointment of and review by the new GP, some of these referrals have since been cancelled.





External Clinical Outings
The Health Centre is responsible for arranging and co-ordinating external clinical outings. There have been 138 clinical appointments attended in the last year and and additional 52 clinical appointments did not proceed for the reasons tabled below. It should be noted that upon appointment of the new GP, outstanding referrals were revisitied to establish if these were still considered appropriate for external investigation. As a consequence the "Other" referrals were deemed to be no longer required and were managed either within the GP clinic or via clinical letter for advice / opinion to the relevant speciality.

Since the COVID pandemic, some external clinics are continuing to have telephone consultations with patients. Six patients had a telephone consultation with a consultant in the past year.

Table 8: Trend data for the last 5 years

Reason for Non Attendance	2018	2019	2020	2021	2022
Clinical team	6	2	4	4	**2**
Poor mental health	6	4	0	1	**3**
Patient refusal	7	2	6	1	**8**
Staffing issues	14	9	0	1	**4**
Paperwork	0	1	1	0	**0**
No Transport	0	1	0	0	**0**
No longer required	2	0	1	1	**2**
Weather	6	0	0	0	**0**
Cancelled by external hospital	6	14	10	8	**12**
Poor Physical Health	3	0	0	0	**2**
Transferred	1	0	0	0	**0**
Other patients at ECT			6	2	**2**
Other outings scheduled			6	2	**3**
Evening/weekend appt			4	1	**1**
COVID-19			6	2	**9**
Other			7	4	**6**
Total	51	33	51	27	**52**

Unscheduled/Emergency Clinical Outings
18 patients attended Accident and Emergency on 36 occasions. Of the 36 attendances, 14 of these resulted in emergency admission to acute ward.

NHS24/Out of Hours/Urgent Care
There has been 14 telephone advice calls to NHS24.

Dental Service
The dental clinic takes place ½ day twice per week with the dental nurse being in clinic 2 full days per week.The dental nurse covers additional tasks such as administration tasks, compiling the triage list of patients and receiving and back loading of equipment for external sterilisation. Future work will

involve the recommencement of oral health and exposure clinics which were paused during the Covid pandemic.

able 9: Trend data for the last five years

	2018	2019	2020	2021	2022
Patients treated	105	101	98	104	**102**
Interventions	442	408	308	313	**317**
Refusal	52	47	52	41	**32**
Unable to attend			9	9	**6**
Oral hygiene interventions	4	1	3	8	**0**

Reasons for unable to attend:
3 appointments were rescheduled due to time constraints in dental clinic
2 appointments were rescheduled due to COVID on ward
1 appointment was rescheduled due to problems with dental equipment

Podiatry
The SLA with NHS Lanarkshire provides ongoing podiatry care on a weekly ½ day basis.

The table below shows that in addition to those patients with identified foot conditions requiring review, patients with poor mental health, physical disability, learning difficulties and obesity also attend. All patients are offered an initial appointment post admission. Nail Surgery clinics are scheduled into routine sessions, along with Annual Diabetic Foot Screening as mentioned above.

Table 10: Trend data for the last 5 years

	2018	2019	2020	2021	2022
Assessment/treatment interventions	81	90	69	79	77
Care interventions	343	583	291	301	324
Self care patients	53	59	64	76	69
Patients refusing podiatry assessment	4	1	2	12	32
New patients awaiting review	10	2	13	3	7
Nail surgery	4	3	3	5	0

Physiotherapy
The SLA with NHS Lanarkshire provides ongoing physiotherapy care on a weekly ½ day basis.The physiotherapist provides assessment, interventions and education to patients within a mental health context who can be referred by nursing staff, OT, RMO/SHO and other health professionals.

Table 11: Number of Referrals/Treatments 2021-2022

	No of patients	No of interventions
Refer to physiotherapy	43	68
Seen by physiotherapist	43	144
Joint consultation with other health professional	0	0
Discharged from physio	11	N/A
DNA physio appointment	19	30
Patient's symptoms resolved	4	N/A
Clinical Reason		
Chronic low back pain	5	10
Acute low back pain	7	14
Acute neck pain	1	2
Chronic neck pain	1	1
Pain in upper limb	5	16
Shoulder pain	6	12
Pain in lower limb	10	19
Knee pain	6	13

Foot pain	1	4
Respiratory physio	0	0
Procedures relating to mobility	1	1
Provision of mobility aid	0	0
Falls assessment	0	0
Exercise assessment complete	0	0

Food, Fluid and Nutrition (FFN)/Food in Hospitals (FiH)
The FiH review (HFS) was conducted as a peer review in January 2021 – the Hospital received positive feedback in the report published in September 2022 and noted areas of good practice relating to patient feedback regarding meals, the 30:30 QI work regarding fruit being in the hospital shop and the population needs based assessment 'clear and comprehensive review of nutritional care'.

The national Catering production strategy (NCIS) now agree to adopt Synbiotix for food and meal ordering and nutritional analysis. It is anticipated the system will streamline the procuring of food and sundries, provide adequate standardised recipes, ensure compliance with EU Allergen regulations (2013) and meet the need of the FiH analysis. Work has just commenced on this formally in October 2022.

No FFN training has occurred due to the pandemic and staffing pressures. REHIS Food and Health training is hoped for late 2022/early 2023.

Nutritional Care Plans – Health and Wellbeing plans are under review following annual audit to help improve nutritional care alongside physical care and monitoring. These will be called Nutrition and Physical Health Care Plans supported by NST completion and a new physical health checklist.

A new permanent Health Psychologist post has been agreed and will start in October 2022.

The table below shows monthly weights (from the 12th of each month) reported via the Tableau system. Tableau reports data via total population, including data not obtained, so % BMI figures appear reduced in the new way of recording. This has been agreed as the way forward.

Table 12a: TSH Patient BMI 2022 (Jan to Sept)

Date	Jan	Feb	Mar	April	May	June	July	Aug	Sep
	%	%	%	%	%	%	%	%	%
No BMI	2.7	1.8	1.8	4.5	6.9	2.6	4.5	7.1	9.9
Normal	9	10.1	11.4	11.6	11.2	12.0	8.0	8.8	9.0
Over wt	27.9	28.4	28.9	28.6	27.6	27.4	32.1	33.6	28.8
BMI >30	35.1	34.9	33.3	34.8	31.9	36.8	35.7	35.4	35.1
BMI 35-39.9	20.7	19.3	17.5	15.2	16.4	15.4	13.4	9.7	11.7
BMI >40	3.6	4.6	6.1	4.5	5.2	5.1	5.4	4.4	4.5
Total over wt/obe	88.2	87.2	85.8	83.1	81.1	84.7	86.6	83.1	80.1
Under wt	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9

The table below provides comparison data year on year from 2014 to current.

Table 12b: TSH Patient BMI 2014 to 2022

BMI Range	2014 Patients (%)	2015 Patients (%)	2016 Patients (%)	2017 Patients (%)	2018 Patients (%)	2019 Patients (%)	2020 Patients (%)	2021 Patients (%)	2022 Patients (%)
<18.5 Underweight	0	1 (0.8)	0	0	0	0	0	1 (0.9)	1 (0.9)
18.5-24.9 Healthy	8 (6.9)	17 (14.2)	14 (13.3)	16 (15.8)	15 (14)	12 (12.1)	15 (14.4)	7 (6.1)	14 (12)
25-29.9 overweight	46 (39.7)	38 (31.7)	30 (28.6)	28 (27.7)	34 (31.8)	34 (34.3)	36 (36.5)	47 (41.2)	32 (27.4)
30-34.9 Obese	36 (31)	35 (29.2)	36 (34.3)	28 (27.7)	34 (31.8)	31 (31.3)	27 (26.9)	38 (33.3)	43 (36.8)
35-39.9 Obese	19 (16.4)	19 (15.8)	16 (15.2)	25 (24.8)	17 (15.9)	16 (16.2)	15 (14.4)	19 (16.7)	18 (15.4)
>40 obese	7 (6)	10 (8.3)	9 (8.6)	4 (4)	7 (6.5)	6 (6.1)	2 (1.9)	2 (1.8)	6 (5.1)
30->40 Total obese	62 (53.4)	64 (53.3)	61 (58.1)	57 (56.4)	58 (54.2)	53 (53.5)	44 (43.2)	59 (51.8)	67 (57.3)
Participating Population	116	120	105	101	107	99	99	113	114
Refusals	7 (5.7)	6 (4.8)	6 (5.4)	9 (8.2)	2 (1.8)	7 (6.6)	6 (5.8)	1 (0.9)	3 (2.6)
Total Population	123	126	111	110	109	106	105	114	117

The following table highlights, for each respected year of admission, how much weight on average a patient gained 12 months later. During 2020/21 23 patients were admitted and overall a reduction in average weight gain was seen in the data compared to previous years. The range of weight loss was -11.7 to a gain of + 29.6kg, showing bigger losses and less gains than previous years. This year was remarkably different for all patients, given a period of lockdown, when daily activity was facilitated, however takeaways, placements, visits and shop access was ceased.

Table 13: Patient Weight gain 1 year following admission

Year of admission	% weight gain 1 year after admission	Based on number of patients staying 1 year	Range of % weight change (kg)
2010/11	18	19	-5 to 52
2012/3	11	17	-2 to 63
2013/4	21	26	-28.7 to 56
2014/5	16.5	15	-4.96 to 55.7
2015/6	21.9	16	-22.7 to 92.8
2016/7	21.7	23	-3.92 to 50.45
2017/8	13.1	17	-1.68 to 43.34
2018/19	18.1	18	-0.5 to 64.1
2019/20	16.03	22	-4.6 to 35.6
2020/21	9.2	23	-11.7 to 29.6

As the following table shows, in June 2022 approximately 86.2% (of known) patients had a waist circumference that identifies them ‘at risk’ of CVD, which mirrors 2019 levels of 85%, only a slight percentage change of those being in the healthy range (13.8% vs 15.6%) in 2020.

Table 14: Waist Circumference Data - June 2022

	% known pts (94)	Number pts	% total patients (109)	Number pts
Ok	13.8	13	11.9	13
At risk	86.2	81	74.3	81
No data	-	15	13.8	15

	100%	94	100%	109

Counterweight
In the latter part of 2020, 6 patients commenced the Counterweight Plus weight loss plan, 1 dropped out and all lost weight ranging from 4.7kg to 14.7kg, most of these patients had Diabetes Mellitus or pre Diabetes. The 4 patients still within the Hospital have increased in weight further to the end of the programme ranging from 1.5 kg to 9.7kg however all remain under their original starting weight. The remaining patient has continued to lose weight (26kg since starting). A further 6 started in January 2021 and all have lost weight ranging from 1.3kg (dropped out after 3 weeks) to over 18kg 16 weeks later and ongoing. During 2022 4 patients have commenced the program, 1 was a relapse patient. All have lost weight and outcome data is awaited.

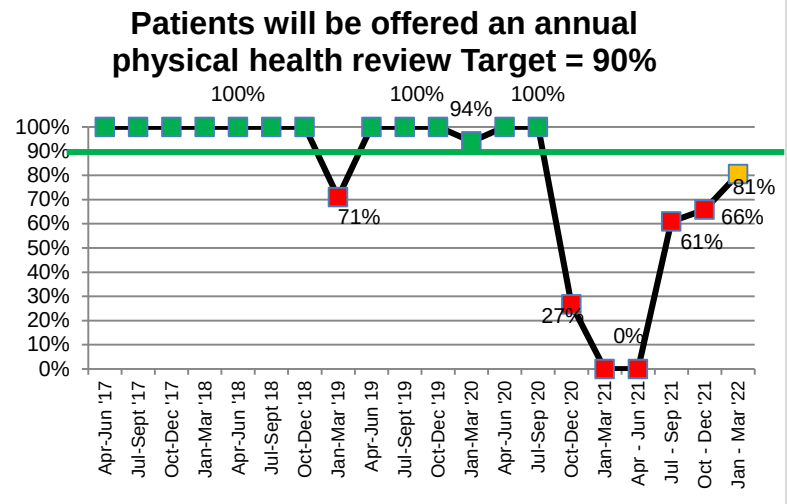
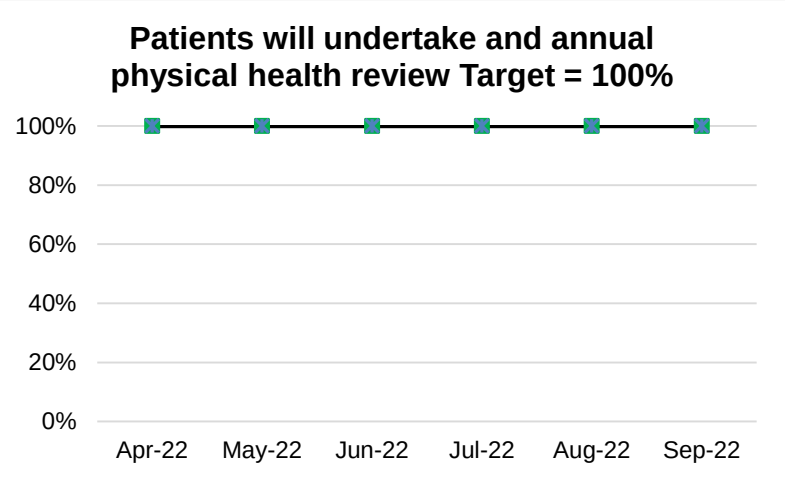
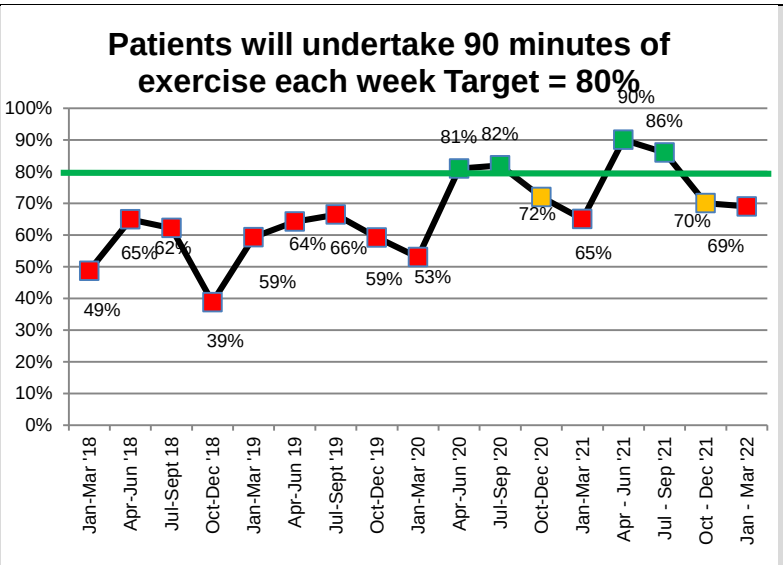
During 2022 our target group has included Diabetic and pre diabetic/at risk.

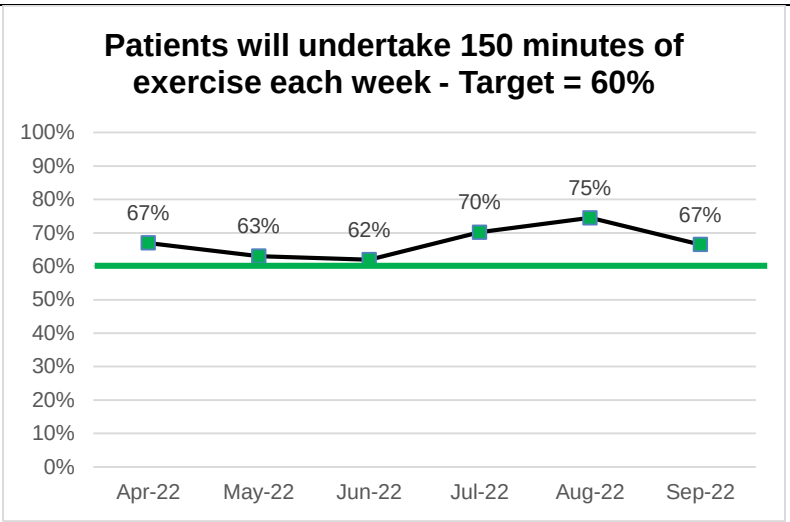
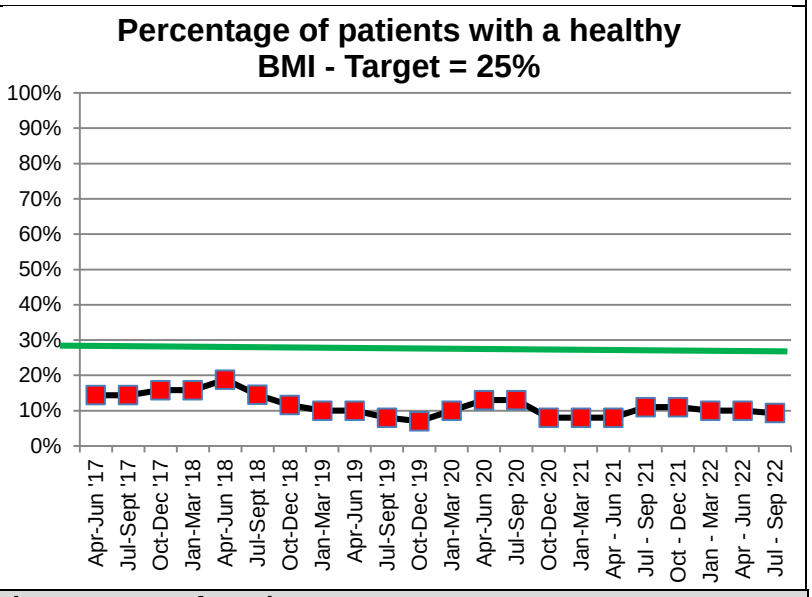
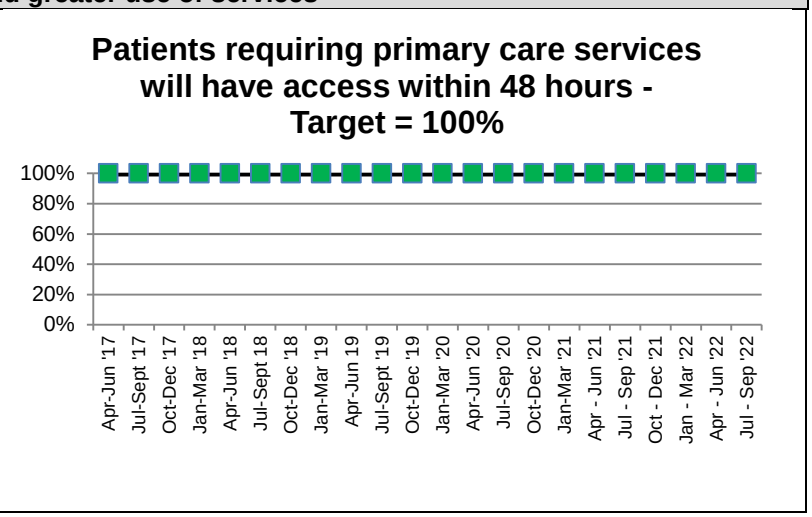
3. Table 15: Comparison with Last Year's Planned QA/QI Activity

Rec	Description	Completed Yes/No	Further actions
1	Establishing the remit of 'Counterweight plus' as an evidenced based weight loss intervention for obesity and those with pre diabetes (diagnosed up to 6 years).	Yes (ongoing)	Data and outcomes will continue to be monitored through PHSG. Ongoing to target pre-diabetics and high risk patients. Data going forward will be included in a national data base
2	Embedding HWP into practice, monitoring implementation and robust evaluation and audit of compliance rates. Developing HWP into practical resources for the ID patients, with support from the SLT, to make these purposeful for this patient group. Use of case studies and 'test patients' to help understand and gain confirmation of the legal perspective regarding managing high risk patients	No	Data and outcomes will continue to be monitored through the PHSG. HWB plans are under review in conjunction with practice development. The plans will be called nutrition and physical health care. It is anticipated this will form part of the admission process and ongoing.
3	Deliver 9 Health Improvement events	Yes (ongoing)	Health Improvement events were postponed due to the restrictions in place related to COVID19. This has now been recommenced.
4	The amalgamation of the HLG and Healthy Eating Groups (OT led) to streamline and support healthy eating and key nutritional messages with evaluating and outcome monitoring.	Yes	The amalgamation of the HLG and Healthy Eating Group is complete and a new manual has been written. The new group commenced in January 2020 but had to stop due to covid restrictions on group membership. The group re-commenced in September 2022
5	Continue to develop, supporting and monitoring the Supporting Healthy Choices (SHC) agenda	No	A new SHC Plan has gone to the Board and will be actioned under a separate remit. A post for SHC Project Manager has been recruited to.

4. Performance against Key Performance Indicators (Please note that there are 2 KPI's which have been changed therefore a second chart has been added for both to show data from implementation in April 2022)

Table 16

KPI	Trend Data	Trends over time
Health Improvement – Improving healthy life expectance and encouraging healthy lifestyles		
90% of patients will be offered an annual physical health review (Ended March 2022)	The target continued to be achieved from Apr 17 however achievement dropped to 71% in Jan-Mar 19. It did return to 100% in Apr through Dec 19. Achievement decreased to 93.94% between Jan – Mar 20 although did not fall under the target of 90%. This reason for decrease was due to Covid 19. Acheivement dropped due to KPI review and ongoing work to correctly reflect the uptake and quality of physical health care provided as per the Annual Health Review. Q1 of 2022 showed further improvement.	
100% of patients will undertake an annual phyiscal health overview (Commenced April 2022)	As at April 2022, this above KPI was amended to incorporate the uptake of an annual physical health review by all of our patients, rather than the previous data collection of an offering of a review. This KPI now charts the completion of an annual physical health overview by the Practice Nurse. The Practice Nurse then refers appropriate patients on for face to face review by the GP. The GP conducts these consultations to complete the physical assessment of the annual health review. This KPI has been achieved during Q1 and Q2.	
80% of patients will undertake 90 minutes of moderate exercise each week (Ended March 2022)	Recording of patients' physical activity started in 2018. The allocated target (60%) was met. Target was increased to 80% and remained unachieved until 2020. Target was achieved through Apr-June 2020 where it reached 81%. This was mainly due to the number of escorted walks provided to patients as a result of Covid 19 and the reduction in normal activity services being offered at this time.Target has been achieved from Apr to Sept 2021 at highest levels recorded. Achievement dropped during the winter period.	

60% of patients will undertake 150 minutes of moderate physical activity per week (Commenced April 2022)	At the Board meeting in June 2022, the Board agreed to change the corporate Key Performance Indicator from 80% of patients will achieve 90 minutes of moderate physical activity per week to 60% of patients will achieve 150 minutes of moderate physical activity per week following guidance released by the WHO and reviewed by the PHSG. This change was implemented from 1st April 2022 and will be reviewed after 4 quarters data to assess whether the target should be increased to 70% for 2023/24. Target was achieved in Q1 and Q2.	
25% reduction in the number of patients with a BMI over 40 and a further 5% reduction in the number of patients with a BMI over 30.	Between Apr-Jun 18 patients in the "healthy" BMI category reached 18.8% and 81.2% remained in the unhealthy category. During 2019 patients in the "heathier" category continued to be around 10% with 90% being in the unhealthy catergory. Between Oct-Dec 19 patients with a heathier BMI decreased to 7%. Patients in the "heathier" catergory increased and between Apr-Jun 2020 reached 13%. Patients in the "healthier" category dipped to a low of 7% at the start of 2021 however have increased in Jun –Sept to 11%. This KPI continues to be unachieved as figures remain at similar levels.	
Access to Service – Patients have quicker, easier and greater use of services		
100% of patients requiring primary care services will have access within 48 hours	The Health Centre is currently continuing to meet the target of 100%.	

5. Quality Assurance Activity

Audits

Cancelled Clinical Outings Audit
Given the work done by the new GP into reviewing referrals, the noticeable reduction in the numbers of clinical outings being cancelled and the length of time it would take in order to collate

enough measurable data, the group agreed that this audit would be paused and that should the situation change, the audit can be recommenced at any time.

Physical Health Monitoring Equipment Audit
A sub-group was created to take forward the actions from the audit completed in August 2021. Progress on this has been slow due to the impact of Covid outbreaks and resulting restrictions as well as prolonged resourcing pressures. During the course of this work it has been identified that the title given to the "Treatment Rooms" within the wards is misleading given that the layout and build of the rooms mean they can be used as dispensaries with the only purpose built Treatment Room within the hospital being located in the Health Centre. Work is ongoing.

NST and HWP (previously NCP) Audit
This audit had previously been postponed given the pending introduction of the new Nutrition and Physical Health Care Plans. Due to the delay of the launch of this, the audit will take place in October 2022 concentrating on NST completion only with the full audit anticipated again in 2023.

Patient Attendance at Meals Audit
During the review period 1 to 7 May 2022, Daily Patient Checklists were used to individually record each patient's attendance during breakfast, lunch and dinner of each day. Results were extremely positive with an overall average of 95% of meals being attended. The PHSG agreed that the 1 action to be taken was to update both the Food, Fluid and Nutritional Care Policy and the Standard Operating Procedures for Patient Food and Fluid Provision for all Ward Based Staff regarding the process to be followed if patients miss consecutive meals. This has been completed.

Trend Reporting
Data is collected and analysed each month in relation to physical activity, BMI and patient spend in the shop with any trends reported so the Physical Health Steering Group can take action.

National and local evidence based guidelines and standards
Over the review period (1 October 2021 to 30 September 2022), 51 guidelines/standards were reviewed by the PHSG. Forty three were deemed to be either not relevant or were covered by a similar guideline. Of the remaining 8 guidelines/standards, 1 had varying degrees of relevancy to physical health services within the Hospital and was sent out for information purposes. There were Evaluation Matrices conducted for 3 of the 7 remaining guidelines/standards whilst a decision is currently pending regarding the 4 remaining documents.

Table 17: Breakdown of documents reviewed

Body	Total documents reviewed	Documents for information	Evaluation Matrix required
HIS	1	0	1
NICE	50	1	6 (4 currently awaiting final decision re relevancy)

The 7 guidelines/standards that required evaluation matrices are noted below.

Table 18: Details of evaluation matrices required

Publishing Body & date	Title	Current situation
HIS Jan 2022	Sexual Health Standards	Content agreed by PHSG in August 2022 with 100% compliance achieved.
NICE June 2022	NG219 - Gout: diagnosis & management	Completed gap anlaysis to be presented to PHSG at November meeting for review
NICE Nov 2021	NG208 - Heart valve disease presenting in adults: Investigation & management	With Pratice nurse / GP to review content re relevancy to TSH & advise if gap analysis required however this will need to be prioritised against other reviews taking place
NICE April 2022	NG128 - Stroke & transient ischaemic attack in over 16s:	Gap analysis currently with Pratice nurse / GP to be completed

	diagnosis & initial management	
NICE June 2022	NG220 – Multiple sclerosis in adults: Management UPDATED	With Pratice nurse / GP to review content re relevancy to TSH & advise if gap analysis required however this will need to be prioritised against other reviews taking place
NICE July 2022	NG191 - Pneumonia in adults: diagnosis & management	With Pratice nurse / GP to review content re relevancy to TSH & advise if gap analysis required however this will need to be prioritised against other reviews taking place
NICE	NG 211 – Rehabilitation after traumatic injury	Gap analysis currently being completed by review group. Anticipated completion of draft by end of October 2022.

An Action Plan detailing work ongoing from outstanding recommendations is attached to this report and the group are requested to agree completion has been achieved (Appendix 2).

Healthy Living Group (HLG)
The re-establishment of the HLG under the psychological therapies group therapy remit aims to deliver this program bi-annually. During 2019, the HLG had not been delivered, however plans were agreed regarding aiming to deliver 2 programs during 2020. This was initiated and commenced in February 2020 however due to the pandemic was stopped. A new group has commenced in September 2022 involving 6 patients.

The new HLG for patients with intellectual disability (written by the trainee health psychologist) was delivered by health psychology, dietetics, a clinical nurse specialist and supporting staff during 2019. It will be delivered as required.

6. Quality Improvement Activity

Sports Leadership
Over the past 12 months one Level 4 Sports Leadership course, which enabled patients to further their skills in leading and supporting others was facilitated and completed. 5 patients participated and successfully obtained the qualification.

The Sports Volunteers were reintroduced in August 2021 with the service reopening. Our Volunteers were involved in leading warm up sessions, planning sporting events and mentoring peers and have been involved in supporting a number of patients on a 1:1 basis. They have been involved in cicuit training and supporting the outdoor Bikeablity sessions.

There are now 5 Volunteers within the department (2 of our original cohort of 3 remain. 1 patient was discharge from the hopstal and an additional 3 patients were successfully recrtuited to this role in October 2021).

Two Sports Leadership courses commenced in October 2022. Level 4 has 7 patients participating and Level 5 has 3 patients participating. These are likely to be completed by December 2022 / January 2023.

Change of Key Performance Indicator (KPI)
Work was carried out to formalise a change in KPI from 80% of all patients should achieve 90 minutes of moderate physical activity per week to 60% of all patients should achieve 150 minutes of moderate physical activity per week further to a review of WHO guidance. This has now been agreed and is actively in place across the Hospital. Information leaflets to support educating patients about the change and make suggestions as to how they could achieve this were produced jointly by occupational therapy, health psychology and communications. This included a monitoring sheet to support patients in taking ownership of their physical activity levels. Health and Wellbeing Promotion Boards September 2022 display shared information to all patients on all wards informing them of the updated target with additional suggestions of how to achieve the target.

An audit of patient interest checklists was carried out to gather information on patients preferences of activities to support the organisation in providing meaningful activities to patients and thus hopefully boosting engagement with physical activities. This information has been discussed with Skye Centre colleagues and consideration of the responses given. In summary, patients expressed benefit to a varied timetable of activities and there was appreciation for events such as “Couch to 5km” and charity events as motivators. In addition, The Board were particularly interested in how patients who are not typically interested by physical activities were to be encouraged to engage; the Sports department have reached out to the occupational therapy team and joint work is ongoing to target those patients by running specific sessions whereby there will be less patients in the area to reduce stressors and provide increased support.

Work is underway jointly with the Patient Partnership Group (PPG) to consider the best ways to encourage participation with the new target. Patients have shared ideas of how physical activity will fit within the new clinical model, highlighting that our newly admitted population are less likely to be physically fit or sufficiently motivated to engage in 150 minutes of moderate physical activity per week. From an occupational therapy perspective, activity of all kinds should be provided as part of the daily ward routine, specifically in the admissions service, and it is therefore expected that physical activity will be included within this.

It is expected that as patients progress to treatment and recovery phase of their journey they will take more responsibility over their own routine including use of regular grounds access and placements. Finally, upon arrival at transitions, it would be understood that patients should be independently managing their physical activity levels, specifically managing their own time over evenings and weekends to do physical activity – perhaps ward / hub based sports volunteer led classes or access to hub gyms.

Appointment of New GP
The appointment of a new GP within the Health Centre has resulted in significant improvements taking place with additional improvements still ongoing. An example of this is the GP commencing venesection on 2 patients, this has significantly reduced external clinical outings for treatment of same (a minimum of 1 outing per week over 16 weeks). In addition, the GP will also provide minor surgery on the patient group within the hospital, which again will reduce the need for external clinical outings.

7. Planned Quality Assurance/Quality Improvement for the next year

- Continue to monitor patient’s physical activity with the new target of 150 min/week by 60% of the patients in TSH
- Monitor local KPI regarding weight gain following admission and ongoing being limited to 5%
- Continue to monitor the timescales in when patients Sports induction are completed
- Supporting key dietary messages, to promote good nutritional care and healthy eating within TSH.
- Impliment new Nutrition and Physical Health Care Plans and commence audit review process
- Continue to progress Supporting Healthy Choices action plan and implimentation

Appendix 1

Governance arrangements for Committee

Membership
The Chair of the group will be appointed by the Medical Director. Members are appointed by the group, membership will be reviewed annually and reported as part of normal monitoring mechanisms. Members will also be asked to disseminate, discussions and agreement from the committee to other relevant groups and committees, as agreed within the group membership table.

- Consultant Psychiatrist (Chair)
- Specialist Trainee
- Practice Nurse
- Lead Dietitian
- Catering Manager (vacant at present)
- Skye Centre Manager
- Occupational Therapy Representative
- Clinical Quality Representative
- Nursing Representative
- Nursing Practice Development/SNIC
- Psychology Representative
- Health Psychologist
- Pharmacy Representative (as required)
- Admin Co-ordinator

Frequency
Meetings will be six weekly.

Work Plan
The Workplan is reviewed as required

Management Structure
The group will submit 12 monthly reports to the Clinical Governance Committee. In addition, the group will submit 6 monthly progress reports to the Clinical Governance group providing an update summary based on the recommendations set out in the 12 monthly report.

Next Review
The Physical Health Steering Group will submit a six monthly update on the Key Challenges for the to the Clinical Governance Group and the 12 month Report will be submitted to the Clinical Governance Committee.

PHSG - Guidelines and Standards Action Plan – Outstanding actions from previously completed gap analysis

Guideline & Outstanding Recommendation	Person Responsible	Update	Projected Completion Date
British Association for Psychopharmacology (BAP) guidelines – The management of weight gain, metabolic disturbances and cardiovascular risk associated with psychosis and antipsychotic drug treatment		Date reviewed at Clinical Governance: November 2016	
Clinical commissioning groups and trusts, working with clinicians in both primary and secondary care, need to ensure that appropriate agreements are in place with regard to who takes the lead responsibility for the monitoring and management of physical health for people with psychosis at the different stages of their care. This should include sharing of core clinical information between primary and secondary care.	Dr Khan / J Garrity	Further to the original audit conducted, work has recommenced following the temporary pause due to covid. Compliance is much improved however ongoing work regarding CTM practice has impacted the final achievement. This work should be completed in October 2002 and the outcomes reviewed therafter.	2018 Lewis Pilot – March Mull pilot – June Iona – Sept Arran - Oct
Royal College of Nursing – Parity of Esteem: Delivering physical health equality for those with serious mental health needs		Date reviewed at PHSG: 11/09/2019	
Pressure area care and VTE (venous thromboembolism)	K Burnett/ M Topping/ Dr Neville	To be taken forward as part of the HIS Pressure Ulcer Standards review Reviewed a number of risk assessments and tools and the Waterlow risk assessment seems most suitable. Time frames for re-assessment to be considered and will be incorporated into Health & Wellbeing nursing assessment. When patient specific process would follow pressure ulcer flow chart which is pending sign off from PHSG in October meeting.	August 2022
HIS – General Standards for Neurological Care and Support		Date reviewed at PHSG: 13/11/2019	
People living with neurological conditions can access treatment in line with relevant condition-specific guidance and standards where available.	M Topping / Clinical Quality	Although the review group felt that practice complies, they have suggested an audit of patients with epilepsy against the national guidelines to ensure adherence. Audit currently on hold until appointment of new Practice Nurse 02/22 – Included with CQ list of audits that Junior Doctors could conduct whilst on placement at TSH. Close liaison with Health Centre would be required.	Dec 2023
HIS Standards – Prevention and management of pressure ulcers		Date reviewed at PHSG: 11/08/2021	
1.1 For the prevention and management of pressure ulcers, the organisation can demonstrate: - implementation of national and local policies, procedures, guidance and standards - a multidisciplinary approach - collection, monitoring and review of data with action plans as required - an education and training programme - ongoing quality improvement - adherence to duty of candour regulations and responsibilities.	K Burnett/ M Topping	Partial achievement re MDT approach and duty of candour. Further guidance required which could be achieved via completion of a flowchart. Draft flow chart developed, currently being discussed in context of Health & Wellbeing nursing assessment. Learnpro module has been completed. Learnpro module details to be included in flowchart which is nearing completion. Draft to be brought to PHSG for review and agreement in October meeting.	August 2022
1.3 There are locally-agreed pathways and procedures for the prevention and management of pressure ulcers, which: - include response times	K Burnett/ M Topping	To be incorporated into flowchart when being developed 12/21 – Meetings taking place with hope of flow chart being developed soon	August 2022

- facilitate cross-organisational support, appropriate referral processes and access to specialist advice and equipment when indicated - detail escalation levels and reporting processes if access to specialist advice and equipment is not available when required.		2/22 - Draft flow chart developed, currently being discussed in context of Health & Wellbeing nursing assessment 7/22 – Meeting arranged with KB/MT/MB/JK in order to move forward 9/22 – Flowchart nearing completion. To be brought to PHSG for review and agreement in October meeting.	
5.2 Regular reassessment of risk is undertaken, using a structured and validated tool (see Standard 4) when: - an observed or reported change has occurred in the person's condition or changes are noted upon skin inspection - the person (and/or their representative) reports a change - the person is transferred to another location or care setting within the same organisation. Where appropriate, the person-centred care plan is revised (see Standards 6 and 7).	K Burnett/ M Topping	Do complete a needs assessment tool as and when required however could tighten process via flowchart.Draft flow chart developed, currently being discussed in context of Health & Wellbeing nursing assessment. Flowchart nearing completion. To be brought to PHSG for review and agreement in October meeting.	August 2022
6.1 The person-centred care plan is agreed with the person (and/or their representative), and includes: - the outcome from the risk assessment and skin inspection - identification and management of other risks or contributing factors, including, pain, skin tone, incontinence or nutritional compromise (SSKIN care bundle) - frequency of repositioning - frequency of skin inspection - requirements for equipment - skin cleansing and maintenance regime - cross-references to other relevant care plans, such as falls risk or nutrition - details of self-management strategies and information - planned reassessment of risk and care plan.	M Topping/ M Crothall/ Mull Nursing (TBI)	Care plans completed however awareness required around pressure ulcers Links with improvement in other actions. Complete the admission waterlow score and then follow the flow chart for monitoring. This will ensure that the health centre is made aware of any changes immediately following the review. They will be co-ordinating care/onward referrals. Flowchart nearing completion. To be brought to PHSG for review and agreement in October meeting.	August 2022
Scottish Government – Diabetes Framework		Date reviewed at PHSG: 11/08/2021	
3. Weight management services should provide a single point of entry for a tiered weight management service.23 Learning from good practice in Scotland suggests that a single point of entry helps to streamline the referral process and remove barriers to access by minimising confusion among professionals referring into services and those wishing to self-refer.	F Waddell	Current open referral process. Single point of entry and referral pathway to be discussed and agreed. Meeting with practice nurse, nursing rep and clinical team rep arranged and draft flowchart in development 07/22 – no further progress on this due to staffing/COVID – meeting for July TBA	December 2021
3. Weight management services should work to develop local relationships and actively engage with and promote awareness of weight management services with potential referrers to the service – in particular, work to strengthen links with primary care. This should also include awareness raising around the option for self-referral. This should include communicating details such as: how to refer to the service (including the option for self-referral), what the service offers,	F Waddell	Promotion of Counterweight Plus programme. Health Awareness days. Health Champions. Patients self-refer. Need to "re-advertise". Consider timing of when delivering information to patients i.e. not at point of admission when patient is too mentally unwell On hold due to new staffing/training needs. Dec poster re Jan wt loss plans Dec posters produced and displayed re groups, however groups on hold due to COVID and staffing pressures. Referral pathway clarity is part of flowchart development.	December 2021

who the service is for, where the service is run, and what time, the training qualifications of staff delivering the service.		Group was due to start in May then June, various challenges and is for discussion on 6th July. Rescheduled meeting re slim and trim now 4th July. HLG on hold. Pathway/referral flowchart meeting anticipated later this month.	
3. Weight management services should as part of this awareness raising, NHS Boards may wish to consider offering training on initiating sensitive behaviour change conversations related to weight management (See section 9 below for more detail).	S Dunlop	Supporting Health Choices recommendations. As per Public Health England "Managing a healthy weight in adult secure services" - Staff are encouraged but could be supported better with further education to enable informed discussion with patients out with specialist groups. Some staff have CBT/MI training, some have basic level. Training within staff inductions varies across clinical disciplines i.e. included for AHP/Sports. Staff are required to complete an Introduction to food safety online module. Healthy eating modules. Dietetics have a tiered approach to to nutritional related training in place. HWP, HWMP/CPA, content in CTM meetings, Health Champions received training in healthy conversations. Caution re challenges of expecting staff who are overweight to engage in this intervention. We have heard that some staff with medical cause for being overweight/those with health related eating disorders do not feel it is safe for them to be expected to have these interactions with patients. ID ward currently work to a behaviour change model. Further training to be considered Meeting with Louise Kennedy, Sandra Dunlop and Frances Waddell to discuss training needs and potential options for delivery. Proposing to implement a tiered training model that will incorporate 3 levels of training aligned to the Behaviour Change Development Framework. Level 1 –Behaviour change literacy - Aims to increase practitioner awareness of what influences health and wellbeing and their role in supporting patients to make positive health and lifestyle related choices and behaviour changes. Target date for launch is 1 April 2022. Level 2 – Brief advice & brief interventions - Aims to develop practitioner knowledge and confidence in raising issues and delivering brief advice and brief interventions to support behaviour change (including understanding of the MAP model and how it can be applied to help patients initiate and sustain behaviour change). Implementation date tbc. Level 3 – Motivational interviewing and skills development – Aims to enhance practitioner competence and confidence in applying appropriate behaviour change techniques to motivate and encourage patient engagement with specific behaviour change (e.g. weight management/reduction; physical activity). Implementation date tbc. Meeting scheduled for 4th March re learning module development Draft storyboard (i.e. script) developed for the Level 1 Behaviour Change Literacy awareness module. Technical build of the module is currently in progress with a revised launch date of 1 May 2022. (Slippage in planned timescale has been due to staff absence and associated resource/capacity issues and competing work priorities.) ED/wt stigmas awareness via journal club In March, and diet week in June.	June 2022

3. Weight management services should give consideration to those people that would like to self-manage their weight – referrers should be informed of where to signpost to approved digital and other resources to support their weight management, including the option to self-refer if their circumstances change and/or additional care is required.	F Waddell/L Kennedy/M Topping	Work currently being conducted by Digital Inclusion Group (DIG) and Patients Learning Centre re patients being able to access a digital resource. Currently patients can be provided with self-help advice and information leaflets etc. Access electronically to information - may be options via learning centre, to access resources. Work by DIG may take some considerable time however is on their agenda. Re referrals, practice nurse and dietetics, following approval by PHSG, will include this in the management of overweight and obesity flowchart that includes what happens with referrals, and where they are signposted too Re scheduled meeting re slim and trim 4th July. DIG work pending.	Dec 2023 (DIG dependant)
4.Weight management services should put in place 'a clear and explicit pathway and guidelines for triage and assessment for all people referred to the weight management service'	F Waddell	Not required within TSH setting however currently use Weight Management Pathway. Need to identify and use national assessment - Weight management history screening tools are being scoped for use. Draft flowchart in development No further progress on this due to staffing/COVID – meeting TBA	December 2021
4. Weight management services should ensure all referrals are to weight management services are received at a central triage point within a designated Health Board†, where individuals are then referred to the weight management programme best suited to their needs or receive further assessment.	F Waddell	Most referrals currently made direct to Dietetic Department however needs to be formalised. Discussions to take place and agreement to be reached regarding central contact point Draft flowchart in development Re scope of patients being carried out 03/22. No further progress on this due to staffing/COVID – meeting TBA	June 2022
4. Weight management services should consider triaging individuals with severe or complex obesity to a tier 3 service in the following circumstances: - Uncontrolled eating behaviours that are causing clinically significant distress and require further assessment.	F Waddell/L Kennedy/M Topping	Discussed within MDT. Weight Management Pathway. Need to include further within Weight Management Pathway National tools under review for improving assessment. Fits into draft flowchart referral process development. Tentative meeting arranged for early April. Work around admission screening regarding weight management history that is ongoing within dietetics No further progress on this due to staffing/COVID – meeting TBA	December 2021
6.Weight management services should ensure robust assessment including patients' current diabetes control and clinical management plus other co-morbidities. Psychological/behavioural markers to identify eating disorder risk and disordered eating history should also be assessed due to the higher risks associated with more restrictive dietary patterns	F Waddell	Diabetes control, clinical management, morbidities routinely assessed, CTM will discuss with Psychology if concerns. Eating disorder risk not routinely assessed by formal assessment unless identified informally. National eating disorders screening tool to be adopted where appropriate Weight management history screening tools are being scoped for use. wt screen for all, ED as required – part of B6 project. National tools under review for improving assessment. Fits into draft flowchart referral process development. Slow progress with this is ongoing, meeting TBA	July 2022
6.Weight management services should ensure patients receive ongoing monitoring of weight, blood glucose and blood pressure to assess ongoing diabetes control, potential remission status and importantly review of any medications required – may be provided by dietitian delivering programme or qualified healthcare staff. Professional Protocols for medical monitoring form a key component of Counterweight Plus.	F Waddell	Weekly and 3 monthly monitoring conducted and recorded within Vision. Professional protocol to be drafted Fits into draft flowchart referral process development. This is recorded in Rio and vision. To help collaborate information, paper copies have been used on the wards to collate info for the database.	December 2021

6.Weight management services should ensure systems are put in place to recommence medications where patients drop out of the intensive programme having hadmedications withdrawn at baseline.	M Topping/M Wright	Done informally with communication between health centre and Dr. Professional protocol to be drafted Relevant departmental folder of information to be developed to ensure all disciplines involved use the same resources. Discussion regarding flow chart to support this process in Nov and Dec with Practice Nurse and dietetics - Fits into draft flowchart referral process development. Ongoing informally at present	December 2021
6.Weight Management Services should adopt the following inclusion criteria for programmes containing an LELD/TDR stage : (Written informed consent, Men and women aged 20–65 years, all ethnicities (in line with current evidence – but exception cases may be made),Body Mass Index (BMI) >27 kg/m2 (in line with current evidence – regarding the increased chance of remission but exception cases may be made) T2DM of duration 0–6 years (diagnosis as per clinical guidelines), HbA1c > 48 mmol/mol within last 12 months, If HbA1c >42<48mmol/mol patient must be on oral hypoglycaemic agents, Established medical management of condition and prescribed medications	F Waddell/L Kennedy	Utilised as appropriate. Consent obtained via participation into project. To be written into protocols and referral process Fits into draft flowchart referral process development. Included via MDT however not formally collated and documented. Flowchart development required. Work around admission screening regarding weight management history that is ongoing within dietetics	December 2021
8. Weight management services should be aware that health professionals may find it challenging to approach the subject of weight and can struggle to talk to people about this in a sensitive manner. Barriers include concern about upset, time, extent of their role, lack of knowledge of what to say and of knowledge of local services.23 NHS Boards should therefore consider providing training to support health and care professionals to have sensitive conversations about weight management	S Dunlop	Supporting Health Choices recommendations. As per Public Health England "Managing a healthy weight in adult secure services" - Staff are encouraged but could be supported better with further education to enable informed discussion with patients out with specialist groups. Some staff have CBT/MI training, some have basic level. Training within staff inductions varies across clinical disciplines i.e. included for AHP/Sports. Staff are required to complete an Introduction to food safety online module. Healthy eating modules. Health Champions received training in healthy conversations. Caution re challenges of expecting staff who are overweight to engage in this intervention. We have heard that some staff with medical cause for being overweight/those with health related eating disorders do not feel it is safe for them to b expected to have these interactions with patients. Further training to be considered See Point 3. Meeting arranged in December with SD, LK and FW to discuss.This issue will be progressed as part of Level 2 and Level 3 training.	June 2022
8. Weight management services should be aware that healthcare professionals can have stigmatising attitudes and, in some cases, fail to provide appropriate advice and access to treatment. Services should offer training and education on weight stigma and bias in order to help remove barriers that may otherwise interfere with provision of care for patients with obesity. This will help to improve treatment accessibility and reduce adverse patient behaviours such as avoiding appointments and not reporting concerns to healthcare providers.	S Dunlop	Nursing staff acknowledge that further training would be beneficial. Further training to be considered Meeting with SD and LK on 3rd Dec to discuss. Also, the level 1 training will also incorporate input on weight stigma and bias to help remove barriers that may interfere with provision of care for patients with obesity. See comments in point 3. This issue will be progressed as part of Level 2 and Level 3 training.	March 2022
4.2 Assessment and documentation of the risk of developing pressure ulcers or further damage to existing pressure ulcers is carried out based on professional and clinical judgement as soon as possible after admission to, or contact with, the care service.	K Burnett/ M Topping	Complete body map and assessment upon day of admission however paperwork required updating to comply with standards. Waterlow has been added into required admission documentation.	

PHSG - Guidelines and Standards Action Plan – Achieved actions from previously completed gap analysis

Scottish Government – Diabetes Framework			Date reviewed at PHSG: 11/08/2021
b) Services should have a central list of all facilities and equipment required. The list should include details of safe working loads, product dimensions, as well as where specific equipment is located and how to access it.	H Connor	Central storage of equipment within Skye Centre and training equipment within Islay Conference Centre. Estates maintain lists for hospital owned lifting equipment i.e. patient hoists (200 kgs). AHP have list of additional equipment with additional information available from Procurement. AHP to further enhance list of equipment	Completed December 2021
c) Weight management services should include both tier 2 & tier 3 services as described by Figure 1: Tiered approach to prevention & management of overweight and obesity for adults. Further details are given throughout this document regarding referral criteria & suitable interventions for each tier.	F Waddell	Weight Management Pathway under review to include tiers required. Completion of the development of tiers 10/21 - Wt management plan has been reviewed and tiers incorporated.	Completed September 2021
1.Weight Management Services should ensure programmes and support are tailored to local need. To do this services should undertake a robust assessment of local need and consult with their local population and frontline staff to better understand their needs. This will help to identify any barriers and facilitators to uptake and completion of programmes and ensure that services are designed in a way which better meets the needs of the local populations	F Waddell/ L Kennedy	Local need is defined with the Food, Fluid and Nutrition Policy. The Supporting Healthy Choices Route Map is the hospitals strategy document for weight management. Groups are tailored to suit forensic population i.e. Healthy Living Group (HLG), Counterweight Plus, Diabetes Group, HLG for Intellectual Disabilities. Update SHC Route Map to include further links with Diabetes Local need is defined with the Food, Fluid and Nutrition Policy and at CPA's. We have also undertaken an assessment of local need for staff and patients. We have competed research with patients looking at facilitators and barriers to weight maintenance and research with staff looking at facilitators and barriers to supporting patients with their physical health. In addition in order to meet local need The Healthy Living group is reviewed after each cohort to ensure it meets the needs of the patients and the manual will be updated this year	Completed Mar 2022
2.Services should have a central list of all facilities and equipment required. The list should include details of safe working loads, product dimensions, as well as where specific equipment is located and how to access it.	H Connor	Central storage of equipment within Skye Centre and training equipment within Islay Conference Centre. Estates maintain lists for hospital owned lifting equipment i.e. patient hoists (200 kgs). AHP have list of additional equipment with additional information available from Procurement. AHP to further enhance list of equipment	Completed Nov 2021
3. Weight management services should include both tier 2 and tier 3 services as described by Figure 1: Tiered approach to prevention and management of overweight and obesity for adults. Further details are given throughout this document regarding referral criteria and suitable interventions for each tier.	F Waddell	Weight Management Pathway under review to include tiers required. Completion of the development of tiers. Wt management plan has been reviewed and tiers incorporated.	Completed Sept 2021
3. Weight management services should include both the option for self-referral and referral from health and social care and other professionals, including: GPs, practice nurses, physiotherapists and all other AHPs, diabetes specialists, social care and mental health services, dietetic teams, leisure services, smoking cessation, respiratory care, community link workers and so on. NHS Boards should also actively	F Waddell	Open to referral from members of MDT or self referral from patient. Recirculate Weight Management Pathway for information and awareness	Completed Nov 2021

promote awareness of referral pathways into weight management services, locally (see further detail below).			
5.In addition to the practical sessions individuals should also be supported and empowered to meet CMO's (2011) guidelines on physical activity and reducing sedentary behaviour within their own lifestyles.	J Garrity	TSH previously adhered to 90 mins and is currently in the process of ensuring adherence to WHO guidance of 150 mins. KPI's to be increased. Will be implemented formally at the start of the new financial year – April 2022	July 2021
8.Weight management services should be aware that individuals living with obesity experience a range of physical and psychological challenges as a consequence of obesity. It is therefore essential that interventions in weight management integrate psychological awareness and techniques to address this. Clinical and/or health psychologists could be involved in training and supporting staff to develop psychological understanding and developing psychological practice. Appropriate training and in-service support should be used to ensure quality standards across all services	L Kennedy	Clinical Psychologists and Trainee Health Psychologist involved within groups. Further training to be considered The Healthy Living Group is a psychologically informed weight management intervention that incorporates evidence based practice and psychological techniques. The content of the programme is reviewed annually to ensure that it is adapted to reflect developments in weight management research and practice. Other weight management interventions within the hospital need to be reviewed to ensure that they incorporate psychological elements. Clinical / health psychologists will be involved in the design and facilitation of the proposed tiered training model.	Completed Feb 2022
9.Weight management services should audit reasons for non-engagement – this is an important consideration. This can help to ensure that services are being designed to meet the needs of the local service users. Feedback is essential to ensure that services are reactive to poor attendance or disengagement, to help improve engagement and impact of the service.*	L Kennedy	Done informally. Consider linking in with wider piece of psychology work Referrals to the Healthy Living Group are kept on a central database for audit purposes. Any individual who drops out of treatment would be followed up to gather feedback as to why they have disengaged with treatment. Drop-out rates in the group are low. We do audit dropout rates in the HLG and follow up any patients who have dropped out, although dropout rates are low. There is a huge national data set that goes along with counterweight and we keep our own basic follow up data.	Completed Feb 2022
HIS Standards – Prevention and management of pressure ulcers		Date reviewed at PHSG: 11/08/2021	
1.4 There is timely, effective and person-centred communication, documentation and transfer of information to ensure continuity of care between teams and settings.	M Topping/ M Crothall	Practice complies but could be improved. Communication via MDT and Health Centre with links to tissue viability nurse if required. Information recorded within RiO and Vision. There has been link work undertaken between Health Centre and Tissue Viability Colleagues within NHS Lanarkshire so we do now have a link between services	Completed Nov 2021
2.1 The organisation implements a comprehensive and multifaceted education and training programme that includes: - an assessment of staff training needs that is responsive to staff roles, responsibilities and workplace setting - validated online tools, such as the Creating Viable Options tool - training and continuing professional development plans, including updates for pressure ulcer prevention and management - guidelines, policies, assessment tools and care planning - application of quality improvement methodology for pressure ulcer prevention and management, including service developments - evaluation of the provision, quality and uptake of training.	M Topping/ M Crothall	Partial compliance via CPD however more training required. See NES module – could some of this be used within the TSH Physical Health Module (clinical staff only – is this mandatory)? Link to point 1.4. Module currently remains optional rather than mandatory. Learning Centre have advised that LearnPro module titled "Prevention and Management of Pressure Ulcers" is available to all staff however is not currently included within the mandatory training module so is only optional. We hope to implement this as mandatory basis with a 3 yearly review. Partnerships have been established with Lanarkshire's Tissue Viability service and can be referred to when required for additional training and person specific advice.	Completed Feb 2022
2.2 The organisation is committed to delivering education and training programmes for pressure ulcer prevention and management, appropriate to roles and workplace setting, which include:	K Burnett/ M Topping/ M Crothall	Partial compliance though not in relation to training and education for pressure ulcers. Aspects listed will be captured informally within day to day practice as and when	Completed Feb 2022

- initial assessment and reassessment of risk, including contributing factors, such as frailty, limited mobility and underlying health condition - person-centred care planning for prevention of pressure ulcers, including management of risk - assessment, grading and person-centred care planning - prevention and management of wounds and systemic infection - the importance of a multidisciplinary approach, such as access to specialist advice, treatment and equipment.		required though highlight the small numbers of patients having had pressure ulcers. Need to formalise and can incorporate into suggested flowchart. Link to 2.1 External training completed by Practice Nurse and member of AHP staff. Felt training would be more relevant to Nursing than AHP in order to grade pressure ulcers. Work done on progressing a flow chart – agreement reached that Pressure ulcers graded 2 or above should be datixed and a referral made to tissue viability as per NHS Lanarkshire's process. It has been agreed that Waterlow Ax will be completed on admission and thereafter monthly unless clinically indicated dependant on score and then refer to guidance re risk status and frequency and onward referral to be made to tissue viability via health centre.	
2.4 All staff have access to clear guidance on: - their roles and responsibilities in relation to pressure ulcer prevention and management - identifying and addressing their own continuing professional development, education and training needs.	K Burnett/ M Topping	Partial compliance around achievement of CPD. Clear guidance will be developed as part of flowchart Flow chart complete and has been passed to practice development. Email sent to Learning Centre recommending training become mandatory for clinical staff.	Completed Feb 2022
4.1 A structured and validated risk assessment tool is used to support professional and clinical judgement. For babies, children and young people at risk of developing pressure ulcers, an age-appropriate structured risk assessment tool is used.	K Burnett/ M Topping	Partial relevance given TSH admission criteria is 18 years of age and over. Waterlow Assessment chart used but not routinely – PURA risk assessment to be launched. Could be better provided for access on wards. PPURA risk assessment not deemed appropriate following further review and integration with admission process. Waterlow in place and being used routinely	Completed August 2022
5.1 A structured and validated risk assessment tool is used to support professional and clinical judgement for each reassessment. For babies, children and young people at risk of developing pressure ulcers, an age appropriate structured risk assessment tool is used.	K Burnett/ M Topping	Partial relevance given TSH admission criteria is 18 years of age and over. Waterlow Assessment chart used but not routinely – PURA risk assessment to be launched. Could be better provided for access on wards. PPURA risk assessment not deemed appropriate following further review and integration with admission process. Meeting arranged with KB/MT/MB/JK in order to move forward	Completed August 2022
7.1 Everyone with identified pressure ulcers will receive a holistic assessment. This will be completed by an appropriately trained health or social care professional who will: - undertake a holistic pressure ulcer assessment, which includes grading the pressure ulcers, using validated structured tools - complete a holistic wound assessment using validated structured tools - develop and implement a person-centred treatment plan for pressure ulcer management, with an identified review period and cross reference to other relevant care plans, including nutrition and risk of falls - assess the requirement for equipment and dressings or therapies to assist in the management of pressure ulcers and prevention of further skin breakdown - develop a skin cleansing and maintenance regime - carry out regular assessment of pressure ulcers	K Burnett/ M Topping	Aspects listed will be captured informally within day to day practice as and when required though highlight the small numbers of patients having had pressure ulcers. Need to formalise and can incorporate into flowchart. Draft flow chart developed – at this stage care will be directed by the PN/Health Centre Tissue viability would be referred to and until grade 2 wound charts would be used as directed by the health centre.	Completed Feb 2022

- escalate any concerns through the local reporting process - demonstrate good record-keeping.			
7.3 For all pressure ulcers that have developed while a person is in care, a review is undertaken with appropriate investigation, identification of learning and reporting of actions implemented, as part of ongoing improvement. When a person has been transferred between care settings with existing pressure ulcers, the referring service is notified so it can undertake an appropriate review.	K Burnett/ M Topping	To be incorporated within flowchart Meetings taking place with hope of flow chart being developed soon This information will be passed to receiving unit as part of the physical health transfer documentation Datix grade 2 and above – and recommend carrying out Waterlow Ax on patients return to TSH if the patient has been boarded elsewhere e.g. UHW for a period of 7 days. Health centre to oversee and request.	Completed Feb 2022