NHS SCOTLAND

THE STATE HOSPITALS BOARD FOR SCOTLAND

BOARD MEETING

THURSDAY 28 JUNE 2018
1pm

The Boardroom, The State Hospital, Carstairs, ML11 8RP

A G E N D A

1.	**Apologies**		
2.	**Conflict(s) of Interest(s)** To invite Board members to declare any interest(s) in relation to the Agenda Items to be discussed.		
3.	**Minutes** To submit for approval and signature the Minutes of the Board meeting held on 26 April 2018	For Approval	TSH(M)18/03
4.	**Matters Arising:** ➢ Patient Learning – Recruitment of Gardener update	For Noting	Verbal
(a)	**Actions List**	For Noting	Paper No. 18/27
5.	**Chair's Report**	For Noting	Verbal
	CLINICAL GOVERNANCE		
6.	**Annual Report of Clinical Governance Committee For Year ended 31 March 2018** Report of Chair of Committee	For Approval	Paper No. 18/28
7.	**Service Transformation and Sustainability - Update** Report of the Director of Nursing & AHPs	For Noting	Paper No. 18/29
8.	**Safe and Effective Staffing** Report of the Director of Nursing & AHPs	For Noting	Paper No. 18/30
9.	**Skye Centre Annual Report** Report of the Director of Nursing & AHPs	For Noting	Paper No. 18/31
10.	**Supporting Healthy Choices** Report of the Medical Director	For Noting	Paper No. 18/32
11.	**Clinical Governance Committee** Draft Minutes – 10 May 2018	For Noting	CG(M) 18/02
	STAFF GOVERNANCE		
12.	**Draft Workforce Plan** Report of the Interim Human Resources Director	For Approval	Paper No. 18/33

13.	**Annual Report of Staff Governance Committee For Year ended 31 March 2018** Report of the Chair of Committee	For Approval	Paper No. 18/34
14.	**Annual Report of Remuneration Committee For Year ended 31 March 2018** Report of the Chair of Committee	For Approval	Paper No. 18/35
15.	**Staff Governance Committee** Approved Minutes – 5 April 2018	For Noting	SG(M) 18/01

CORPORATE GOVERNANCE

16.	**Report on the Annual Accounts For Year ended 31 March 2018** Report of the Finance & Performance Management Director	For Approval	Paper No. 18/36
17.	**Annual Report of the Audit Committee For Year ended 31 March 2018** Report of the Chair of Committee	For Approval	Paper No. 18/37
18.	**International Travel Request** Report of the Chief Executive	For Approval	Paper No. 18/38
19.	**Finance Report as at 31 May 2018** Report of the Finance & Performance Management Director	For Noting	Paper No. 18/39
20.	**LDP Performance Report 2017/18** Report of the Finance & Performance Management Director	For Noting	Paper No. 18/40
21.	**eHealth Annual Report** Report of the Finance & Performance Management Director	For Noting	Paper No. 18/41
22.	**Foreign Travel Approval – Forensic Network Staff** Report of the Chief Executive	For Approval	Paper No. 18/42
23.	**Audit Committee** Draft Minutes – 5 April 2018	For Noting	A(M)18/02
24.	**Chief Executive's Report**	For Noting	Paper No. 18/43
25.	**Any Other Business**		

DATE & TIME OF NEXT MEETING

26. Thursday 23 August 2018, 9.45am in the Boardroom, at The State Hospital, Carstairs ML11 8RP

27. EXCLUSION OF PUBLIC AND PRESS

To consider whether to approve a motion to exclude the Public and press during consideration of the items listed as Part II of the Agenda in view of the confidential nature of the business to be transacted.

NHS SCOTLAND

THE STATE HOSPITALS BOARD FOR SCOTLAND ***TSH(M)18/03***

Minutes of the meeting of The State Hospitals Board for Scotland held on Thursday 26 April 2018 at 9.45am in the Boardroom, The State Hospital, Carstairs.

Chair:	Terry Currie
Present:	
Non Executive Director	Bill Brackenridge
Non Executive Director	Elizabeth Carmichael
Chief Executive	James Crichton
Employee Director	Anne Gillan
Non Executive Director	Nicholas Johnston
Finance and Performance Management Director	Robin McNaught
Director of Nursing and AHPs	Mark Richards
Medical Director	Lindsay Thomson
Non- Executive Director	Maire Whitehead
In attendance:	
Head of Social Work	Kathy Blessing
Security Director	Doug Irwin
Head of Communications	Carline McCarron
Head of Corporate Planning and Business Support	Monica Merson
Board Secretary	Margaret Smith
Interim HR Director	John White

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

Mr Currie welcomed everyone to the meeting, and in particular Ms Merson who was attending the Board for the first time. He noted that there were no apologies.

<u>NOTED</u>

2 CONFLICTS OF INTEREST

There were no declarations of conflicts of interests from Members in respect of the business to be discussed at this meeting.

<u>NOTED</u>

3 MINUTES OF THE PREVIOUS MEETING

The Minutes of the previous meeting held on 15 February 2018 were noted to be an accurate record of the meeting, subject to minor correction to the name of Dr Jana De Villiers as Approved Medical Practitioner (Item 6).

<u>NOTED</u>

4 ACTION POINTS AND MATTERS ARISING FROM PREVIOUS MEETING

The Board noted progress on the action points from the last meeting. Mark Richards provided an update in relation Hand Hygiene which had been discussed at the Clinical Governance Group on 25 April due to the variation noted in one hub. This had been highlighted to the Chair of the Infection Control Committee and the Lead Nurse responsible for this area.

NOTED

5 CHAIR'S REPORT

Mr Currie updated members in regard to use of charitable assets, following the recent events within NHS Tayside. Mr Paul Gray – Chief Executive of NHSScotland had written to all Board Chairs seeking explicit assurance on the following: that all funds allocated since the guidance was issued in 2013 have been awarded and used appropriately in furtherance of the charitable purposes of the charity, that retrospective awards were not permitted and that there were no exceptions to this; that the Board's external audit for 2017/18 would specifically cover these two points and report on them as part of the audit opinion.

Mr Currie confirmed that he had responded on 24 April 2018 to confirm that the Endowment Fund for The State Hospital (TSH) was disestablished in March 2011 with the residual sum of £306.19 used during that year for patient and staff welfare specifically relating to sports activities. Further, that there had been no retrospective awards made in relation to Endowment Funds. This letter also provided assurance that the external audit would cover these points and that the external auditors would report on them within their 2017/18 opinion.

Members noted an update from Mr Currie on the main issues discussed at the most recent NHS Scotland Chairs Meeting which had taken place on 23 April 2018. The Cabinet Secretary for Health and Sport had not been scheduled to attend.

The meeting had included a number of interesting presentations including an update on the new GP contract which came into force on 1 April 2018. The Chairs had noted the intention that that in the short term benefits would accrue in terms of reduced non-medical workload and sustainability of practices. In the medium to long term it was envisaged that there would be a reduction in unwarranted variation between GP practices. A change in culture was also hoped for with clinical and management relationships based on trust. It was also hoped that there would be significant improvement in the use of data and the resultant intelligence for the benefit of local public health.

There had been a presentation on Public Health Reform with a focus to reduce levels of avoidable disease, stop the medicalisation of social problems; and recognition that the creation of wellbeing was not a result that the NHS could bring into being. To this end, a new relationship needed to be formed with the public that shared challenges and sought shared solutions. The Public Health priorities would be published shortly with a new body – Public Health Scotland – being launched in late 2019.

Mr Currie advised that he was encouraged by this direction of travel in relation to the GP contract and public health reform within the overall context of the transformation of care delivery within NHSScotland, and emphasised the need for focus on the implementation of change.

The NHS Chairs Meeting had received a presentation from Dr John Colvin on progress on various medical training initiatives including the Professional Compliance Analysis Tool for junior doctors, medical leadership development, International Medical training Fellowships and Global Citizenship in NHSScotland. Ms Smith would pass copies of these papers to the Medical Director and the Interim Director for Human Resources.

Action – Ms Smith

At the meeting the Chair of NHS Forth Valley, Mr Alex Linkston, had introduced a paper regarding Youth Employment and the Princes Trust. This described the way in which the Trust had successfully run a number of “Get Into Schemes” over a range of sectors, targeting young people who need considerable support and who could not be reached through the Modern Apprenticeship programmes. NHS Chairs had been asked to promote this within their Boards. Ms Smith would pass details of this to the Interim Director for Human Resources.

Action – Ms Smith

The NHS Chairs Meeting had also received a presentation from Mr Geoff Huggins, Scottish Government lead within the digital field. Work was focussed on digital capability within NHSScotland – Mr Huggins had indicated an ultimate goal of one system of governance within eHealth and his presentation had given assurance to the group that serious progress was being made in this essential area.

Mr Currie reminded Members that there was an event being held for Board Members on 14 May 2018, and noted that a very positive response had been received to date. The focus of the meeting would be on governance. Mr Currie advised members that registration for the NHSScotland Event which would be held at the S.E.C.C. in Glasgow on 18 and 19 June 2018.

Mr Currie noted the approach of the 70th Anniversary for the NHS and that an action plan for this was in place. Mr Currie considered that an invitation could be made to Ms Aileen Campbell, Minister for Public Health, to ensure involvement in the events being organised within TSH.

Finally, Mr Currie advised that interviews would be held for the Security Director post on 7 June 2018.

NOTED

6 PATIENT STORY- THE PATIENT PARTNERSHIP GROUP RIVER JOURNEY

The Board received a presentation from the Director for Nursing and AHPs which included a story board from the PPG which had used a Japanese occupational therapy technique – the Kawa model. This was a way of presenting issues as part of a river journey. In this, the PPG had indicated what they considered to be movable or significant obstacles, as well as methods considered to be enablers to help solve perceived difficulties.

Some of the issues presented related to the clinical service delivery model encompassing staff attitude as well as the mix within patient groupings especially patients at different stages of their recovery. Patients had discussed environmental issues – for example the business of day rooms which may mean that patients choose to stay within their rooms. Patients also felt disconnected and left behind in relation to digital technology.

Patients had highlighted experiencing positive benefit from visits and social events, as well as the positive impact of volunteers. They also highly valued the occupational therapy cooking sessions. The recent savings action plan had impacted on patients in terms of not being able to attend sessions in the Skye Centre. Patients were concerned when being cared for by staff who were not familiar to them. Professor Thomson emphasised the importance of consistency in care as well as the professionalism and caring attitudes on the part of staff.

This presentation was received very positively by Members. Mr Currie asked how it was possible to bring forward the views of patients through this work, without staff influencing the results. Mr Richards commended the work of Involvement and Equalities Service (IES) in facilitating and not steering the work as well as to encourage fair and equal contributions from within the patient group.

It was noted that patients were positive in their feedback on catering within the hospital. There was

discussion around funding of the department – and Mr McNaught confirmed that daily spend in this area was higher than the minimum recommended by Scottish government. Mr Crichton highlighted the unique status of the hospital within NHSScotland, and that food for residents was considered to be of great importance over time. Professor Thomson indicated that one difficulty for patients was the compressed nature of the day, meaning that the evening meal was served early in the evening. Mr Irwin noted that this was in keeping with the Patient Day and organisation around this structure throughout TSH.

Mrs Carmichael asked whether the same issues tended to be raised over time – thus indicating that action had not or could not be taken within these areas. It was noted that most issues raised did have actions against them, and that there had to be recognition of the issues that perhaps could not be resolved due to unrealistic expectations. Members asked for an update to the Board, on the actions taken and progress made. Mr Richards would ensure that there was feedback to the PPG from Board Members.

Actions – Mr Richards

NOTED

7 PLANNING FOR LONG TERM SUSTAINABILITY

A paper was received from the Director of Nursing and AHPs which asked the Board to note this planned workstream and that the Senior Management Team had endorsed the creation of a task force to take this forward.

Mr Richards led Members through the paper, highlighting two distinct but interrelated emergent themes for transformational change – workforce and model of care delivery. He outlined the key phases of the process; planning, implementation and review whilst also acknowledging that these may not be progressed in a linear way, with some key pieces of work already in train. There was a recognised need for leadership pauses throughout the process to maintain direction of travel. He advised that an update would be brought to the Board in the Development Session on 31 May 2018.

Mrs Carmichael was pleased to note the success of the savings action plan for 2017/18, and noted the need for a more detailed plan to be brought forward as well as assurance on how it would be achieved, bringing staff on board. Mrs Gillan echoed this, and highlighted the need for speedy engagement with staff side representatives. Mr Richards confirmed that this was planned to take place at the earliest opportunity.

Mr Johnston welcomed the paper and emphasised the need for speed in planning and implementation. At the same time, he cautioned against the possibility of unintended consequences of any change and noted that an update would be brought to the Clinical Governance Committee on 10 May 2018 regarding the clinical impacts of the savings action plan.

Mr Brackenridge was supportive of the paper and also emphasised the need to engage and bring staff on board as this would be essential in making transformational change. Mrs Gillan added that staff were aware of the need for change and would be supportive of positive changes.

In response to a question from Mr Currie on how to affect speed of change, Mr Richards explained that the three phases outlined in the paper were not necessarily distinct and that some actions may be progressed much sooner should there be a recognised need to do so. This was in the context of increasing overtime costs since the start of the new financial year. For example, early consideration would be given to reinstating the 9am to 5pm care model. Professor Thomson outlined the need to be mindful of the impact on individual patient care. This model had been seen to be beneficial for some patients who experienced a more active day as a result. At the same time, the use of the peripatetic care team model i.e. a shared care team had impacted on some of the most severely ill patients and had meant that they had limited number of hours outwith their

rooms each day. This had been carefully monitored by the weekly review teams in terms of impact on individual care plans. Single care teams within a 9am to 5pm model could be given consideration in the longer term from a clinical perspective. Professor Thomson reminded the Board of the Patient Active Day project, and the intention to release ward staff. The project had been successful in increasing patient activity but at the same time experience to date had been that the wards were being kept open, meaning that ward staff were not being released in terms of supporting other areas within the hospital.

It was noted and understood by Members that that staff had volunteered to undertake a change in their shift patterns during February to March 2018.

Mr Currie raised the ward closure during 2017/18, and asked how any measurable benefit would be reflected within this work and reported to the Board. It was agreed that a report should be brought to the Board on this aspect. An update would be brought to the Board in a Development Session scheduled to take place on 31 May 2018.

Action – Mr Richards

Mr Currie thanked Mr Richards for this update, and noted that the Board considered speed to be essential to progress this work.

NOTED

8 HEALTH (TOBACCO, NICOTINE etc and CARE) (SCOTLAND) ACT 2016 –UPDATE PART 4

A paper was received from the Director of Nursing and AHPs which proved the Board with an update on this legislative change which conferred a new legislative duty on Scottish Ministers. The paper provided assurance to the Board on progress within TSH to meeting this duty.

Members were content to note this paper.

NOTED

9 DUTY OF CANDOUR – UPDATE

A paper was received from the Medical Director, which provided Members with an update on progress made on preparation of the implementation of the duty of candour and to endorse the actions required to ensure that TSH was compliant with the procedure.

Professor Thomson introduced the paper to Members and Ms Merson led them through the key highlights. She outlined the work to date on awareness raising as well as the need for further training throughout the hospital. Initially the duty of candour group would review all incidents recorded on Datix to verify how recording was being made, and to ensure that any potential duty of candour incidents were not missed. This would instil confidence in the systems in place. Going forward, there was an expectation that the group could come to rely upon the data recorded. Ms Merson had also taken the opportunity to attend a simulation event in NHS Lothian which had been helpful in respect of transferability of ideas.

It was noted that there would be a continuing role for the Clinical Governance Committee in the reporting on duty of candour incidents in TSH in terms of governance in this area. Professor Thomson confirmed that this information would be contained within the Complaints and Feedback Report.

Mr Currie thanked the team for their work, and noted the good progress made in this area.

NOTED

10 NURSING RESOURCE UTILISATION GROUP – UPDATE

Mr McNaught updated the Board on this work stream, noting that the Project Manager was due to return to work shortly. Work had continued but now had to be completed to bring the work to a conclusion. It was noted that an update would be brought to the Board in this regard.

NOTED

11 CLINICAL GOVERNANCE COMMITTEE

The Board was asked to note the draft Minutes of the Clinical Governance Committee meeting held on 22 February 2018. These minutes would be brought to the next Clinical Governance Committee for approval.

The Chair of the Committee, Mr Johnston noted the minute provided a summary of the key issues discussed in the committee. Mr Crichton added that it had been noted that there had been delays in the completion of Critical Incident Reviews, and that to mitigate this the Head of Risk Management had returned to her substantive post for two days per week and that it was expected that a new Risk Facilitator would start in post in the near future.

NOTED

12 THE NATIONAL HEALTH AND SOCIAL CARE STAFF EXPERIENCE REPORT

A paper was received from the Interim Human Resources Director, which provided an update on the findings of on the National Health and Social Care Staff Experience Report.

Mr White provided Members with a summary of the survey which combined the findings of national iMatter and Dignity at Work surveys. Each Board had received a copy of the national findings as well as the individual findings for their Board.

Overall the findings had been positive for TSH, although it was noted that there was some variance from the national findings in terms of experience of abuse and violence as well as a feeling among staff of being less able to report issues or to report by way of the Whistleblowing Policy. At the same time, it was noted that there had been an increased rate of participation by staff which the Board welcomed.

NOTED

13 STAFF GOVERNANCE COMMITTEE – UPDATE

Mr Brackenridge provided members with an update on the last meeting of the Committee which had taken place on 5 April. He highlighted the discussion at that meeting around appreciation of the huge efforts made by staff to maintain safe and effective care delivery during the period of adverse weather experienced at the beginning of March 2018.

The Committee had also noted the staff absence rate of 10.06% for January which had fallen to 6.97% in February 2018. The latter figure represented the best figure on staff absence for the Board since May 2016.

The minute of the meeting would be available at the next meeting of the Board.

NOTED

14 FINANCE REPORT AS AT 31 MARCH 2018

The Finance Report to 31 March 2018 was submitted to the Board by the Director of Finance, and Members were asked to note the content of this report.

Mr McNaught led Members through the report highlighting the key areas of focus. Within revenue, the earlier adverse financial position had been caused principally by the increased costs of nursing staffing, together with the additional pressure of the National Boards' savings. Following the financial recovery plan, the Board did come back into line with the projected breakeven position.

A Capital underspend was noted which was related to the timing of work on the security and perimeter redevelopment. Mr McNaught emphasised the need to focus on overtime spending in the first quarter of the current financial year. The budget reviews for each directorate had been completed.

Mr Brackenridge requested clarification on the recoupment of VAT from HMRC. Mr McNaught explained that this was related to the status of the hospital in terms of it being a place of residence.

Members discussed progress towards full staff compliment and the impact this could have in reducing excess hours as well as overtime. Mr Richards also advised that use of flexible working e.g. a cohort of nursing staff able to work a flexible one day per week in support of gaps in staffing would also help in this area.

Mr Currie asked for further assurance on any areas of risk of variance from the internal auditors reporting to March 2018, and Mr McNaught provided positive assurance in this regard. Mr Currie also asked about the impact on the 2018/19 of the underspend outlined in relation to capital. Mr McNaught advised that the perimeter project would be built into this budget to negate any effect.

Board Members expressed their heartfelt thanks to staff for all of their efforts which had allowed TSH to reach break-even. The degree of cooperation had been excellent across the site and had been very much appreciated.

NOTED

15 SUMMARY REPORT ON SAVINGS ACTION PLAN

A paper was received from the Director of Nursing and AHPs, which proved the Board with a final summary report on the savings action plan which was delivered from 12 February to 31 March 2018.

Mr Richards summarised this report for Members, noting the actions taken and the monitoring of the impact of these actions especially on the care approach for a small number of patients within the hospital. He described patient feedback as well the small number of complaints received. He confirmed that the Mental Welfare Commission had been fully informed of the actions taken.

Mrs Whitehead asked for clarification around nursing professionals who were PMVA level 2 trained being utilised within wards, and how this fitted with their substantive positions. Mr Richards explained that they had carried on with substantive duties e.g. Infection Control, whilst being able to devote a portion of hours each week in support of the savings action plan.

In response to a question from Mr Brackenridge, Mr Richards confirmed that the costs mitigated of circa £256K had been in relation to nursing overtime, with other savings made across the hospital overall. The use of shared care teams on a 9am to 5pm model had high impact, but also had impacted on a small number of patients. At the same time, other patients had reported some

benefit in the intensity and quality of engagement and activities provided. Mrs Carmichael also raised the impact on the use of the Skye Centre, and Mr Richards confirmed that this had been a more general impact.

Mr Currie thanked Mr Richards for this very worthwhile paper to finalise this process, noting the benefits it had brought.

NOTED

16 DRAFT ANNUAL OPERATIONAL PLAN

A report was submitted to the Board, from the Finance & Performance Management Director, which invited Members to note the draft Annual Operational Plan for 2018/19. This replaced the Local Delivery Plan, following guidance from Scottish Government.

Mr Currie thanked Mr McNaught and underlined the improvement in the format albeit noting that there still required to be specific targets. Mr Crichton added his thanks to Mr McNaught on this excellent piece of work and acknowledged the continuing work in terms of targets to complete the plan.

In response to a question from Mr Brackenridge on monitoring that the Board was track, Mr Crichton confirmed that the process to enable this was underway with the service strategy and the clinical strategy being fed into the overall corporate management objectives.

Mr Brackenridge suggested a specific target for patient BMI be included, and there was discussion around the importance of this in patient health and the obstacles of setting such a target. Healthy choices represented collaborative work between the hospital and patients. There were also other factors to be considered e.g. medication impacting on weight gain. Mr Johnston made the point that BMI was one indicator of overall physical health. Mr Richards advised that this had been a point under discussion at the Clinical Governance Group in terms of health and wellbeing as a target and how to drive change within the hospital. Mr Currie suggested a conversation should be taken forward in relation to all targets.

It was noted than an update would be brought back to the Board in due course.

Action –Mr McNaught

NOTED

17 ANNUAL REVIEW OF STANDING DOCUMENTATION

A paper was submitted to the Board, from the Director of Finance and Performance Management which provided the Board with an update on proposed changes to Standing Documentation. Mr McNaught confirmed that these had been reviewed and approved by the Audit Committee.

The Board reviewed and approved the changes made to Standing Documentation, which were of a minor nature.

AGREED

18 PROJECT BANK ACCOUNTS

A paper was submitted from the Director of Finance and Performance Management, which requested Board approval for opening a Project Bank Account in respect of the Security Upgrade project for which the provisions were within the provisions for implementing as per the Scottish

Public Finance Manual.

The Board was content to approve this proposal.

AGREED

19 AUDIT COMMITTEE – UPDATE

Mrs Carmichael provided Members with a verbal update on the last meeting of the Audit Committee, on 5 April 2018 including reporting from the internal auditors on key areas including sickness and absence rates, recruitment process, eHealth check, and preparation for GDPR.

The internal auditors had noted partial assurance only in relation to sickness and absence. Mr Currie asked whether this had been considered helpful or surprising by the Committee. Mr White advised that this had been helpful in that it was supportive of and added impetus to the improvement plan in place in this area and for the HR Manager to take forward the recommendations from both the audits.

NOTED

20 CHIEF EXECUTIVE'S REPORT

A paper was submitted to the Board by the Chief Executive, which highlighted and provided an update to Members on issues that did not feature elsewhere on the Board's formal agenda.

This included an update on the further progress made during March and April 2018, on the National Boards Delivery Plan. The draft plan had been submitted to Scottish Government on 3 April and would thereafter be presented to the Cabinet Secretary and First Minister.

Mr Crichton thanked Mr Richards for his focus and work on the financial recovery plan as well as all staff for their hard work and flexibility.

Mr Crichton also drew Members' attention to the bed occupancy rate as outlined in his report.

Members were content to note this report.

NOTED

21 ANY OTHER BUSINESS

There were no other items of competent business.

NOTED

22 DATE AND TIME OF NEXT MEETING

The next meeting would take place on Thursday 28 June 2018 at 1pm in the Boardroom, The State Hospital, Carstairs.

NOTED

23 EXCLUSION OF PUBLIC AND PRESS

Members approved a motion to exclude the public and press during consideration of the items listed at Part II of the agenda in view of the confidential nature of the business to be transacted.

<u>AGREED</u>

The meeting concluded at 12.30 pm

ADOPTED BY THE BOARD

CHAIR ____
(Signed Mr Terry Currie)

DATE 26 April 2018

NHS SCOTLAND

MINUTE ACTION POINTS
THE STATE HOSPITALS BOARD FOR SCOTLAND

ACTION NO	AGENDA ITEM NO	ITEM	ACTION POINT	LEAD	TIMESCALE	STATUS
1	5	Chair's Report	To provide copies of medical training initiatives and Prince's Trust papers to Executive Leads	Margaret Smith	Immediate	**Completed**
2	6	Patient Story	To provide feedback to PPG from Board. .	Mark Richards	Immediate	**Completed**
3	7	Planning for Long Term Sustainability	Update to Board Development Session. Report to focus on what measurable benefit of ward closure during 2017/18 had been.	Mark Richards Mark Richards	May 2018	**Completed**

Board Paper 18/28

NHS SCOTLAND

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	28 June 2018
Agenda Reference:	Item No: 6
Sponsoring Director:	Medical Director
Author(s):	Medical Director/Clinical Effectiveness Team Leader
Title of Report:	Clinical Governance Annual Report For Year Ended 31 March 2018
Purpose of Report:	For approval

1 Situation

The attached Clinical Governance Committee Annual report outlines the wide range of activity overseen by the Committee during 2017/18. 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.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives?	
Workforce Implications	n/a
Financial Implications	n/a
Route To Board Which groups were involved in contributing to the paper and recommendations?	Clinical Governance 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

Date Report Prepared:	15 April 2018
Prepared by:	Clinical Effectiveness Team Leader

THE STATE HOSPITALS BOARD FOR SCOTLAND

CLINICAL GOVERNANCE ANNUAL REPORT

1 April 2017 – 31st March 2018

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 governance 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, and subsequently through the Scottish Government's publication of the *Healthcare Improvement Strategy for NHS Scotland* in 2010 which outlines three main quality ambitions:

- Mutually beneficial partnerships between patients, their families and those delivering healthcare services which respect individual needs and values and which demonstrate compassion, continuity, clear communication and shared decision-making.
- There will be no avoidable injury or harm to people from healthcare they receive, and an appropriate, clean and safe environment will be provided for the delivery of healthcare services at all times.
- The most appropriate treatments, interventions, support and services will be provided at the right time to everyone who will benefit, and wasteful or harmful variation will be eradicated.

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 2016/17 and examples of good practice and matters of concern. Improvements to the report format this year include clear reference to the hospital's priority areas, and progress updates on areas of concern noted by the Committee during the year.

2. Committee Chair Members and Attendees

Committee Chair:
Nicholas Johnston, Non-Executive Director

Committee Members:
Maire Whitehead, Non-Executive Director
Elizabeth Carmichael, Non-Executive Director

Attendees:
Terry Currie, NHS Board Chair
James Crichton, Chief Executive
Prof. Lindsay Thomson, Medical Director
Morag Slesser, Head of Psychological Services (until November 2017)
Gary MacPherson, Interim Head of Psychology (from February 2018)
Mark Richards, Director of Nursing and AHPs
Robin McNaught, Finance & Performance Director
Dr Khuram Khan, Chair of Medical Advisory Committee
Monica Merson, Head of Business Support and Corporate Planning (from February 2018)
Sheila Smith, Clinical Effectiveness Team Leader

3. Meetings during 2016/17

During 2017/18 the Clinical Governance Committee met on 4 occasions, in line with its terms of reference. Meetings were held on:
11th May 2017
18th August 2017
9th November 2017
22nd February 2018

4. Reports Considered by the Committee During the Year

All 12 monthly rolling internal governance reports are submitted using the following headings:

- Introduction
- Governance arrangements
- Committee membership
- Role of the committee
- Aims and objectives
- Patient Voice
- Meeting frequency and dates met
- Strategy and workplan
- Management arrangements
- Key pieces of work undertaken during the year [include outcomes]
- Key performance indicators [with data]
- Comparison with last annual report
- Areas of good practice
- Identified issues and potential solutions
- Future areas of work and potential service developments
- Implications
  - Staffing
  - Finance
- Next review date

4.1 12 Monthly Internal Governance Reports

Research Committee/Research Governance and Funding – In May the committee received and approved the 2016/17 Research Committee Annual Report. The reporting period covered was 1st April 2016 to 31st March 2017. The report included information on the key pieces of work including: an overview of the 16th Research and Clinical Effectiveness Conference; an overview of the Forensic Network Research Special Interest Group Conference; data on completed studies; information on journal articles and presentations accepted from State Hospital staff and information on the third point prevalence data collection for the Forensic Network Inpatient Census.

Rehabilitation Services Report - The committee received a report from the Skye Centre Manager at their November meeting. The report provided details of rehabilitation therapies including an update on the work of the Allied Health Professions (AHP) and Skye Centre staff covering the period 1st October 2016 – 30th September 2017. An updated document containing the number of patients currently engaging in rehabilitation services was also tabled. The report provided a Service Overview; Service Delivery; Governance and Management Arrangements; LDP Targets; Data Gathering; Clinical Supervision; an overview

of the work of patient day project; and the future areas of work for the service. An update on the recommendations from last year's report was provided: with regards to Review of Supervision Model - all AHPs are now supervised; work on Integrated Multidisciplinary Working and Supporting Healthy Choices - consultation is ongoing and using Data and Gathering Outcomes has not been progressed but is expected to be achieved in March 2018. The Committee noted that a Lead AHP has been appointed who will be professionally and operationally responsible for the AHP staff group.

Fitness to Practice - The committee received a report in relation to Fitness to Practise at its May meeting. The reporting period covered was 1st April 2016 to 31st March 2017. The report outlined the process for monitoring professional registration status at the State Hospital and provided assurance that all members of staff hold current professional registration. The report highlighted that revalidation for nurses was brought in from 1 April 2016. One failure to revalidate was noted and was being managed in accordance with due process.

Child and Adult Protection – The committee received the report in May 2017 and it covered the period 1st April 2016 – 31st March 2017. The report included key areas of work around keeping children safe; child visits; there were 7 notifications of concern with appropriate investigations and liaison with Social Work colleagues; adult protection referrals increased from 36 to 55 attributed to 23 patients; the main source of harm noted was patient to patient interactions, with 11 referrals relating to allegations regarding the conduct of staff; there is steady progress in all areas of training. 51 of the referrals required no further action following initial enquiries under the ASP legislation with the remaining 4 being subject to additional enquiries/investigations. Whilst there was no cause to proceed to case conference under ASP legislation, on one occasion it was recognised by the Child and Adult Protection Forum that there was outstanding management action to be followed up and possible future practice development. Adjustments have been made to the referral process through updated DATIX and asking staff to consider the three point test at point of submission rather than using DATIX as proxy for adult protection.

Patient Safety - In August the committee received and approved the Patient Safety Report covering the period 1st July 2016 – 30th June 2017. The report noted that the Hospital continues to influence nationally through developing, implementing and sharing its SPSP Mental Health programmes of activity. The report provided an update in respect of progress with all five mental health workstreams, ie Leadership and Culture; Communication at Transitions; Safer Medicines Management; Violence, Restraint and Seclusion Reduction; and Risk Assessment and Planning. Members discussed a range of issues of the report in relation the programme of Leadership Walkrounds which had been reviewed and improved; the Patient Safety Group's bid to be one of five national test sites for improving observation practice which was unfortunately unsuccessful; and the 8 Rights of PRN Psychotropic Medication.

Risk Register – the committee received and noted a report on progress with the Corporate Risk Register at its August meeting. It was noted that the Corporate Risk Register had been subject to full review by internal audit (KPMG) in May 2015 with the report finalising the recommendations being published at the end of January 2016. A further review would take place by new Internal Auditors, RSMUK over the 2017-18 year. All departments have now been asked to provide a local risk register along with the relevant risk assessments and action plans (if indicated) to the Risk Management Team who in turn are collating these centrally.

Infection Control – At the May meeting, the committee noted the progress in the Infection Control Annual Report 2016/17 (covering 1st April 2016 to 31st March 2017) and endorsed the Programme of Work for 2017-18. The report outlined the wide range of Infection Control

activity undertaken within the Hospital and summarises the work conducted within the Infection Control Services. Key achievements over the year included a full review of the uniform policy; clinical waste and environmental audits now linked to Control book audits and inspections undertaken by Senior Charge Nurses or Nursing Team Leaders with the Advanced Practitioner for Infection Control undertaking a quality assurance audit at least once per year.

CPA/MAPPA – At its August meeting, the committee noted the report covering the period 1st July 2016 to 30th June 2017. 100% of transfers, were managed through the CPA process as required by the Local Delivery Plan (LDP). The report evidenced successful implementation of the principles of the Clinical Model. The report identified a number of key areas in relation to Multi Disciplinary CPA attendance; Patient and Carer Involvement; and Strategic Engagement and Representation. The issue of MAPPA expansion, and the assessment of risks posed by certain categories of offender was discussed. It was noted that in the period under review, no existing patients at the Hospital had been identified as potentially meeting the risk of serious harm category. It was agreed that a clearer description of this issue would be included in future reports.

Physical Health Steering Group – In November the committee received and approved the 12 month rolling report from the Physical Health Steering covering the period 1st October 2016 to 30th September 2017. 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. For each of these areas, details were provided of the work undertaken and the performance against Local Delivery Plan (LDP) targets.

Medicines Committee – In November the committee received and approved information on the key pieces of work undertaken throughout the year (1st October 2016 -30th September 2017) by the Medicines Committee. The Medicines Committee oversees all aspects of medicine throughout the hospital including their effective and economic use, policies and clinical audit. Key areas of work this year have included updates of three major medicine policies, approval of guidance on the use of unlicensed intra-muscular clozapine and implementation of a pharmacist prescriber in line with an agreed framework. An extensive programme of Clinical Audit projects has continued (both local and national) as well as working with the Patient Safety Group on local medicine topics. The report noted that the move to receiving supplies from St John's Hospital has been successful. Work in the next 12 months, in addition to core activities will include supporting the project lead in the planning of resources and funding requirements for electronic prescribing.

Psychological Therapies - In February 2018 the committee noted the Department of Psychological Therapies report covering the period 1st January 2017 to 31st December 2017. The report was centred on the six quality dimensions from The Healthcare Quality Strategy for NHS Scotland. Key service developments during 2017 included the Connections programme; Safety and Stabilisation training; sustained focus on healthy living via NES funded health psychology trainees; sharing practice and updates with the Forensic Matrix Implementation Group; delivering external training and producing a referral and guidance booklet. Some of the challenges and opportunities for the service over the coming year were noted included making links with UK Special Hospitals for benchmarking, the Psychological Therapies Workforce Review and sequencing of therapies in collaboration with the iHub Quality Improvement Team.

Forensic Medium and High Secure Care Standards – Action Plan Update - In February 2018 the committee received a report that provided an annual update on the actions agreed following a peer review visit by NHS Quality Improvement Scotland which took place on 8

October 2013. The visit was to assess the hospital against a set of Secure Care Standards for high secure services that were developed by the Forensic Network. The standards include assessment, care planning and treatment, physical health, risk management, physical environment and teams, skills and staffing. It was confirmed that following approval of the Suicide Awareness and Prevention Policy at Senior Management Team, the action plan had been completed.

Medium and High Secure Care Standards Self Assessment 2018 - A report was submitted to the Committee In February 2018 for their information in respect of the peer review visit due to place at the hospital on 27 April 2018 by the Forensic Network. The report included details of the ongoing preparation for the visit in relation to the self assessment, rating scales, service profile form and evidence that requires to be submitted. The submission date is Friday, 6th April 2018.

Clinical Effectiveness Report – In August 2017 the committee noted the 12 monthly report covering 1st April 2016 – 31st March 2017. The report gave information on all clinical audits, quality improvement projects, data from the integrated care pathways and assurances around implementation of the evidence base from national standards and guidelines. A wide range of issues were discussed in relation to concerns expressed in respect of the gap in interventions and involvement by Occupational Therapists and the improvement expected with the recent appointment of the new Head of AHPs; the progress with the review of the Clinical Effectiveness Strategy, which is now part of the Board's QA/QI Strategy and was currently being finalised; and in respect of the broad range of projects undertaken. It was agreed that in future this report would be presented to the Clinical Governance Group and form part of the Group's annual report.

Clinical Governance Group – At the February meeting the committee received the first report from the Clinical Governance Group covering the period 1st April 2017 – 31st December 2018. The group was set up in April 2017 to give assurance on delivering of the following strategic aims of the Board:

- Delivery of safe, effective and person-centred care based on available evidence and best practice.
- Achievement of demonstrable improvements in outcomes including the patient experience.

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: CPA audit results; the Clinical Quality Strategy; evaluation of independent prescribing; multidisciplinary working with social work teams; impact of the DASA inpatient version risk assessment tool; duty of candour and supporting the Healthy Choices Group . The report also highlighted the reinstatement of the Hub Leadership Teams across the hospital.

4.2 Standing Items Considered by the Committee During the Year

Critical Incident Reviews – Two CIR reports were considered during the reporting year. Both had their recommendations and actions agreed. It was noted that data is now included within the Incident Reporting and Patient Restrictions Report to advise the committee how long CIRs are taking to complete.

NHS HIS Reports : Evidence Directorate Strategic Plan – The committee noted the strategic plan published in May 2017. The 4 aims included within the strategic plan are:

- work with NHS boards, Integration Joint Boards and health and social care partnerships to develop high quality, sustainable services resulting from the application of evidence and best practice
- provide responsive advice to services and service users on the effectiveness of medicines, treatments and technologies, from innovation to disinvestment
- respond to the needs of our stakeholders for advice that reflects their requirements both in content, timeliness, reflecting key challenges such as the increase in multimorbidity, and in formats that support implementation, and
- continue to contribute to global knowledge on the generation and use of evidence including approaches to evaluation of improvement programmes, and through our contribution to Healthcare Improvement Scotland's Research Strategic Plan.

An implementation plan was published as a appendix for the Strategic Plan.

Scottish Government Reports: Health and Social Care Standards – My Support, My Life – The Committee received this report for information at its meeting in August 2017. The standards and outcomes set out in the Standards are published in exercise of the Scottish Ministers' powers under section 50 of the Public Services Reform (Scotland) Act 2010 and section 10H of the National Health Service (Scotland) Act 1978. They do not replace previous standards and outcomes relating to healthcare that have already been produced under section 10H of the National Health Service (Scotland) Act 1978 but they will replace the National Care Standards, published in 2002 under section 5 of the Regulation of Care (Scotland) Act 2001. From 1 April 2018 the Standards will be taken into account by the Care Inspectorate, Healthcare Improvement Scotland and other scrutiny bodies in relation to inspections, and registration, of health and care services.

Learning from Complaints and Feedback Report
The quarterly Learning from Complaints and Feedback report was considered at the Clinical Governance Committee at every meeting. This was the second year that complaints and feedback were integrated into one report. It now includes information on the statistics presented in respect of the feedback the Hospital received which encompassed complaints, concerns, comments and suggestions as well as any positive feedback received.
During the year (April 2017) a new complaints model was introduced across Scotland. The new two stage model 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. This has been fully implemented across the hospital and forms the basis for the quarterly reports.

Patient Movement Statistical Information – The committee received 2 reports during the year at its May and November meetings. The May report covered the reporting period 1st September 2016 to 31st March 2017 and the November report covered 1st April 2017 to 30 September 2017. 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 the Clinical Governance Committee at every meeting The report showed the type and the amount 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; those

relating to equipment, facilities and property; and prohibited items brought in by staff which were now recorded in DATIX.

5. Discussion Items During the Year

The discussion items during the year picked up on 2 out of the 3 priority areas for the hospital. The 2 areas were: Clinical Outcome Measures and Healthy Choices (linking to obesity). The third priority, Physical Activity will be a discussion item during 2018.

Clinical Outcome Measures – At its May meeting the committee received a presentation from the Research Manager on the data that is now captured as part of the quarterly clinical outcomes report and the enhancements that have been made to the data. The measures reported quarterly are:

- Violent Incidents
- Moving on – Transfer List
- Relationships – Patient Visits
- Physical Health - BMI
- Patient Skye Centre Activity
- Physical Activity
- Self-Management – Patient attendance at Case Review
- Patient Rate Mental State – CORE

- Violent Incidents. This section now includes a definition of RIDDOR events and a breakdown of the RIDDOR events that have occurred within the reporting period.
- Transfer List. This section has been amended to include further trend data on the hospitals patients transfer list, within the context of the number of discharges and readmissions occurring within each quarter.
- Non Professional Visits. A new chart has been added to provide trend data on the number of patients who receive no non professional visits across the Hospital and down to Hub level.
- Physical Activity. This section has been added to the report and includes initial data from the recording of patient physical activity conducted by Hub clinical staff. The data has been extracted from RiO as an initial example of the data that is available with additional analysis possible for future reports including, breakdown to Hub/Ward level, intensity of activity and type of activity undertaken.
- Patient attendance at Case review. A further table has been added to provide a breakdown of the reasons why patients have not attended their case review within this reporting period. Hubs have been asked were possible to provide details of why those patients who have declined to attend have done so.
- CORE patient self report. In line with comments from Hub and CG Group the CORE data has been simplified to focus solely on the CORE-OM Global Psychological Distress index; however the section also notes very low CORE completion or recording rates for the reporting period.

Healthy Choices– At its November meeting the committee received a presentation from the Lead for the Healthy Choices project. The healthy choices work plan contains 15 recommendations that would prevent / reduce obesity with the aim of reducing harm to patients caused by obesity. The presentation focussed on:

- The external procurement of food items was ceased on 31 October 2017.
- The hospital shop has been re-modelled with stock now being 80% compliant.
- Five patients are taking part in a pilot of the Health and Wellbeing Plans which is being reported on at SMT in November 2017.

- Takeaways are permitted once per month with patients ordering a meal for one person only.
- The traffic light system is used for catering.
- There is a target for all patients to engage in 90 minutes of activity per week.
- There is a plan to amalgamate 3 different groups into one Healthy Living Group and utilise the Health Champions.
- Patients are being encouraged to use internet shopping for non-food items.
- Consideration is being given to buying outdoor equipment for hard to reach patients.

During discussion the following points were raised:

- There has been some debate as to whether the Mental Health Act could be utilised to address obesity. Treatment for physical illness is not covered by the Act and most patients have the capacity to make decisions regarding food choices.
- The Scottish Government's Obesity Strategy was recently launched. Consider whether this contains anything to assist with the next phase of the programme.
- With regards to support from carers, Health and Wellbeing Plans can be negotiated with patients and carers.
- With regard to internet shopping for non-food items, The Head of IT is developing a system to combine this with electronic educational programmes.

Rehabilitation Therapy Services - At its February 2018 meeting the committee received a presentation from the Lead AHP on overview of the AHP service within the hospital and her own role as service lead. Key achievements for the service included the setting up of an Arts Therapies meeting as a group shared referral process and integrated work with the Patient Learning Centre and involvement in planning patient activity days. The development of a falls bundle was also highlighted, and is being progressed through consultation.

An outline of the Service Strategy for 2017 to 2020 was given, with key priorities being health inequalities, hub activity, ward activity and maximising opportunities within the Skye Centre. As part of her presentation, the vision for the service for the future was explained. The emphasis will be on better use of standardised assessment and shared treatment planning to ensure that activity provision meets patient need. Focus will be on more efficient and effective practice, especially use of activity space in the Skye centre. There will also be a focus on engagement with the third sector, with volunteer placements in the Skye centre.

Duty of Candour – The discussion item for August 2017 was Duty of Candour. Members received a presentation from the Medical Director on Duty of Candour, part of the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016. The Act received Royal Assent on 6 April 2016 and introduced a new organisational Duty of Candour on Health, Care and Social Work Services. The implementation date for the Duty of Candour provision will come into effect on 1 April 2018.

The Medical Director summarised the DoC procedure in the Act, the potential DoC incidents, the preparations required, The State Hospital steps to date, and the next steps to be taken.

The next steps that were agreed were to develop and implement a hospital procedure for Duty of Candour and to raise awareness within hospital staff. It was also agreed that relevant staff within the hospital would attend the national training and events surrounding Duty of Candour.

6. Special Topics/Items for Approval

Quality Strategy – The draft Quality Strategy was approved by the Clinical Governance Committee at their November 2017 meeting. There are 7 key goals within the Strategy that will ensure the organisation remains focussed on delivering their 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.

It was agreed that a quality framework will be develop to underpin the key goals of the organisation.

Clinical Governance Annual Stock Take – At its May meeting, the committee received and approved: the Clinical Governance Reporting Structures for 2017-18; the Programme of Work for 2017-18 subsequent to any changes that may arise at future meetings; the Clinical Governance Committee Terms of Reference; and the Clinical Governance Annual Report 2016-2017. The annual report summarised the work of the Committee during the financial year 1st April 2016 – 31st March 2017.

7. Areas of Good Practice identified by the Committee

Adult and Child Protection - high levels of staff completing the online training for Child & Adult Protection

Infection Control - BBV screening will now be part of the routine admission bloods and the success of outbreak management processes within the hospital

Complaints and Feedback – The Hospital has implemented the new NHS Scotland complaints model and reports coming to the Committee are now broken down into stage 1 and stage 2 complaints.

Medicines Committee Report – The change to medication coming from St Johns instead of the Royal Edinburgh was handled very successfully with no negative impact to patients' medication.

Research Committee and Research Funding Committee Report - seeing the patient voice coming through

Psychological Therapies Service Report – The report was deemed well-constructed showing the efficient and effective use of resources.

Physical Health Steering Group – The introduction of a physical activity data form on RiO to capture patients' physical activity both on and off ward was seen as a very positive way forward.

Clinical Governance Group – It was agreed that having all 3 main hospital priorities: obesity, physical activity and outcome measures within their workplan is helping to keep driving the projects forward successfully

CPA/MAPPA - At the August meeting the committee was very happy with the continued positive feedback that is being received from patients about the current transfer processes within the hospital.

8. Matters of Concern to the Committee

Infection Control Committee Report – The Committee had some concerns over the low submission of hand hygiene audit forms from some areas of the hospital.
Update: A change in practice has been implemented to increase the submission rate

Clinical Effectiveness Report – At the August meeting concerns were raised over the continued decline with Occupational Therapy providing reports and attendance at the patients CPA meetings
Update: The new Lead AHP is now in post and improvements have already been seen with this data.

Rehabilitation Therapies Service Report – There were concerns that the report tabled at the Committee in November had a lot of gaps with regards to the impact of the service on patients and the lack of capturing ward based activities
Update: The Committee asked for the Lead AHP to attend the February meeting where she gave a very comprehensive plan for the service and the way forward with future reports.

Incident Reporting and Patient Restrictions Report – at the November meeting concerns were raised over the time taken to complete SUIs and CIRs
Update: The hospital now has a Head of Business Support and Corporate Planning who is currently looking at ways to make the process more time sensitive and ensure that all staff understand the priority that requires to be placed on these.

Child and Adult Protection – It was noted that there were challenges around getting staff off ward to attend the training.
Update: At the August meeting the Director of Nursing & AHPs assured the Committee that staff were now able to attend the training.

Physical Health Steering Group – The levels of obesity in the hospitals patient population.
Update: A discussion item in November was an update from the Healthy Choices Group with various initiatives being closed off e.g. no external food purchases. Patients' weights will be taken in March and June 2018 to see if this has had a positive impact on the weight of the patients.

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.

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.

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.

Members:

- M Whitehead
- N Johnston (Chair)
- E Carmichael

Ex-officio Members

- Terry Currie, Chairperson

In Attendance

- Jim Crichton, Chief Executive
- Prof. Lindsay Thomson, Medical Director
- Head of Psychological Services
- Monica Merson, Head of Corporate Planning and Business Support
- Mark Richards, Director of Nursing & AHPs
- Robin McNaught, Finance & Performance Director
- Dr Khuram Khan, Chair, Medical Advisory Committee
- Sheila Smith, Clinical Effectiveness Team Leader

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 submission 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
- 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 service 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 that arrangements are in place to embed Patient Focus and Public Involvement 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 for approval.

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.

May 2018
Board approved: 28 June 2018
Subject to annual review
Next revision: May 2019

Board Paper 18/29

NHS SCOTLAND

THE STATE HOSPITALS BOARD FOR SCOTLAND

BOARD MEETING

Date of Meeting:	28 June 2018
Agenda Reference:	Item No: 7
Sponsoring Director:	Director of Nursing and AHPs
Author(s):	Director of Nursing and AHPs/Head of Corporate Planning and Business Support
Title of Report:	Update on Service Transformation and Sustainability
Purpose of Report:	For noting

1 SITUATION

This SBAR provides the Board with an update on the work of the Service Transformation and Sustainability Group, including an update on the priority actions agreed at the Board development session on 31 May 2018.

2 BACKGROUND

Achieving sustainable service delivery is a priority focus for the Board and SMT. In February 2018; emergency recovery measures were required to help ensure the near breakeven position, which was achieved by the Board. This was in the face of significant financial pressure as a consequence of nurse staffing costs to meet clinical activity requirements.

It was agreed that a Service Transformational and Sustainability Group should be established to take forward a programme of work to best ensure clinical service sustainability going forward, with two main areas of focus – clinical service delivery and workforce.

To inform actions going forward, a survey of all available clinical staff was undertaken, to which 91 responses were received. The summary of this was circulated in a bulletin to all staff on Friday 8 June.

At a Board development session on 31 May 2018, a small number of priority areas were agreed for action.

3 ASSESSMENT

Ninety-one responses were received to the aforementioned survey, and within the feedback, there were 735 written comments provided. This has been important in informing our planning for the actions we need to take to ensure service sustainability.

We asked staff to rate their personal commitment to and readiness for change, their beliefs about their team's purpose and performance and also about ideas and innovation. The response to this was extremely positive and suggests that those who responded to the survey are ready and willing to be involved in change. This is a very encouraging start and one we hope to build on over the coming months.

Throughout the survey, we asked staff for comments on areas for development and innovation that are important for them. These have been summarised thematically and cover the following areas:

- Clinical service delivery
- Workforce
- Ideas to innovate
- Personal commitment
- Advice

These were presented at a development session held by the Board on 31 May, and following consideration by the Board, a small number of priorities were agreed as priorities areas to focus on:

1. Review of clinical service delivery model (Lead – Medical Director)
2. Testing a 9 to 5 staffing model to support activity (Lead – Director of Nursing and AHPs)
3. Developing electronic rostering (Lead – Finance and Performance Management Director)
4. Focus on improving clinical observation practice through funding provided by Healthcare Improvement Scotland. (Lead – Director of Nursing and AHPs).

Paying full attention to our attendance management challenge was also discussed as an area requiring a continued, specific focus.

There has been a helpful message from our front line staff about the importance of continued communication including face-to-face discussion on the back of this survey. To support this, members of the Transformation and Sustainability group are having conversations with many of staff over the next few weeks so we can build on this feedback and help ensure that as many staff as possible have a voice in influencing and informing service change. Local managers have also been encouraged to have discussions at ward and team level to generate further feedback.

For the four priority areas set out above, a standardised template will be produced by each work-stream lead, which will set out:

- Who will be affected by the proposed change
- What we are trying to achieve
- What the measures of success will be
- What stakeholder engagement will take place
- Impact of change on care quality, safety and costs
- Scoping of potential unintended consequences
- Timescale for delivery
- Resources required
- Potential for financial efficiency or savings.

Examples of templates completed to date are included at Appendix 1. These are working drafts and will be refined over the next 2 weeks.

Workforce considerations will be key in the delivery of these changes. Efficiency and sustainability can be realised through, for example, a different approach to clinical staff resource utilisation in a

reshaped service delivery model. An example of this is our ambition to embed 9-5 working as part of a core, agreed shift pattern for a wider number of our Nursing staff.

Recognising this, proposed changes that affect the workforce were discussed at the Partnership Forum held on 19 June 2018 to ensure that there is formal engagement with union partners at this important time.

4 RECOMMENDATION

The Board is invited to **note** this update, and invite a further progress report at the August meeting of The Board.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Supports the delivery of safe, effective and person centred care and supports mitigation against financial pressures.
Workforce Implications	Potential implications linked to all planned work-streams
Financial Implications	Part of work to be delivered in 18/19 to achieve
Route To Board Which groups were involved in contributing to the paper and recommendations.	Via Service Transformation and Sustainability Group /SMT
Risk Assessment (Outline any significant risks and associated mitigation)	Not formally assessed.
Assessment of Impact on Stakeholder Experience	Responds positively to feedback from staff.
Equality Impact Assessment	Not assessed.

Service Transformation and Sustainability Project

Title: 9-5 staffing model

Description of proposed activity Please describe the activity	To introduce, through a larger scale test of change, a 9-5 model for nurse staffing which will support the delivery of activity. ‘Activity’ in the context of this project is primarily focused on enhanced clinical observation levels, but the scope to build capacity to enable participation in activity within the ward, hub, grounds and Skye Centre will also be considered.
Who will be affected or impacted by the proposed activity? This may directly e.g the proposal may affect fewer than 10 patients, and 50 staff directly and may impact on 25 patients indirectly	The proposed approach is to ask Nursing staff to volunteer to vary from their agreed roster patterns, and to work pre agreed 9-5 shifts to support the delivery of care. This has the potential to affect all staff and all patients, however, the number of patients who are currently on level 3 observations is 7. The number of directly affected staff will be dependent on the number of staff who volunteer to opt in for this change of shift.
What are we trying to achieve? - What is our theory of change? - what are we predicting will happen – by doing x we expect y – what changes can we make that will lead to improvement?	We are trying to ensure that we are putting the right staff, in the right place, at the right time, to best meet activity requirements in as efficient a way as possible. This will help deliver high quality, safe, patient centred care. By having more staff working 9-5, we will target our staffing capacity at times of greatest demand. We predict a reduction in costs through reduced dependency on overtime to meet clinical activity requirements. We may also be able to achieve greater participation in activity through provision of staff to support this.
How will we know change is an improvement – what will we measure?	We will measure: - Shifts worked - Additional hours used

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	- Activity sessions completed - Patient feedback - Staff feedback - Resources required for enhanced obs - DATIX (incidents)
Stakeholders and engagement – provide an overview of who has been involved in developing the proposal and how you have engaged, e.g. discussions, questionnaires, meetings etc	This was tested as a model of working during the financial recovery planning in February and March 2018, and was the single biggest 'high impact' change during that period. Feedback on the impact of this model has been sought from care teams and patients affected. This was closely monitored as a care approach during the recovery period. Feedback on the model has been mixed, with positive views being offered in terms of more targeted, structured engagement being of benefit to some patients, while it was reported as being detrimental to others. In the wider staff engagement survey, having 9-5 staff available to support activity delivery was also a feature of feedback received. The 9-5 staffing model has continued to be utilised for delivery of enhanced clinical observation, with 4 x 9-5 shifts per day currently required.
How will the proposed activity or intervention impact on:	
• Quality of care	Ensuring effective nurse staffing levels during the middle part of the day will support enhanced engagement with our patient group for those on enhanced clinical observation. Increased access to activity.
• Safety for staff and patients	This staffing model will potentially benefit patients who are on enhance observations through enabling planning for structured, focused engagement. We also know that activity has a positive impact on the MH and wellbeing of patients. Supporting our patients to be more actively engaged may have a subsequent positive impact on the therapeutic milieu and thus enhance safety.

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• Cost of service	Looking at the 9-5 model as currently applied, we use 4 x shifts at the moment, realised through overtime. Approximate overtime costs of this model for just 4 staff is £5250 per week. Having staff work this as a rostered shift would be £3150 per week, or a £2000 cost reduction. Where it is clinically appropriate, using the 9-5 model for care potentially halves the shift cost against needing day and back shift staffing.
What are the benefits and drawbacks of proposed activity, particularly thinking about patients and staff.	
• Benefits	Potential for intensive engagement Access to activity Financial (for organisation) Responding to feedback
• Drawbacks	Changes to rosters. More restrictions on care. Can only be implemented where it is clinically appropriate, so making safe assumptions about financial benefits are more challenging. Highly dynamic, as based on presenting needs of patient group.
What potential unexpected consequences are there?	Risk of legal challenge from patient group with regard to a more restrictive approach to care. Increased complaints. Reduced staff morale.
Timeline - How long will this take to implement?	One month.
What resources will be required to support implementation?	No additional resources will be required. An oversight group exists to monitor impact.
What are the savings that could be	Based on current use, savings of £2000 per week.

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realised if this was rolled out across the hospital?	

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Service Transformation and Sustainability Project

Title: Improving Observation Practice

<table>
<tr><td>Description of proposed activity

Please describe the activity</td><td>It is proposed to implement a new model of Observation Practice for patients who are requiring increased levels of nursing observation, due to deterioration in their mental health. The philosophy behind the change is to move from observation to intervention.

The overarching aim of this national initiative is to shift the focus from observation after a patient has deteriorated to early identification of deteriorating mental health and implementing strategies to support the patient to maintain their well being.</td></tr>
<tr><td>Who will be affected or impacted by the proposed activity? This may directly e.g. the proposal may affect fewer than 10 patients, and 50 staff directly and may impact on 25 patients indirectly</td><td>This will have an impact across all wards in the hospital.

It will require all clinical staff to consider how they work in relation to supporting a new way of working with patients.</td></tr>
<tr><td>What are we trying to achieve? What is our theory of change? What are we predicting will happen? By doing x we expect y – What changes can we make that will lead to improvement?</td><td>The aim is to provide a personalised approach to patient care. Observation cannot be viewed in isolation but is one part of the mental health care of the patient. This will require consideration of the following being embedded into practice:
Leadership for change and improvement within teams
Skilful, visible, core workforce
Personalised and aligned care, treatment and safety planning
Early recognition of, and response to, deterioration
Safe and therapeutic environments
Psychotherapeutic interventions and approaches
Rights-based, trauma-informed and recovery-focused culture
Flexible, collaborative care, involving patients' carers
Evidencing the impact of changes on patients' and carers' experiences and outcomes
Test sites have shown a reduction in numbers of patients who require increased levels of observations and dedicated staffing to support this. Improvements in overall approaches to care have led to a shift in focus from reactive to proactive practice.</td></tr>
<tr><td>How will we know change is an improvement – what</td><td>The number of patients on increased observations</td></tr>
</table>

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will we measure?	The number of additional staff required to support increased observations Feedback from patients Feedback from staff
Stakeholders and engagement – provide an overview of who has been involved in developing the proposal and how you have engaged, e.g. discussions, questionnaires, meetings etc	An Oversight Group will be formed to support the implementation of this work. A nurse has been employed to specifically lead on the work.
How will the proposed activity or intervention impact on:	
• Quality of care	Patients should experience an improvement in the quality of care they receive. Staff should be much more responsive to their needs and approaches to care will be more collaborative.
• Safety for staff and patients	Safety will be paramount to the work. By intervening earlier when a patient is deteriorating, this should prevent escalation of behaviours that may cause harm.
• Cost of service	There will be no direct costs to the State Hospital. External funding has been secured for 44 weeks to implement this work.
What are the benefits and drawback of proposed activity, particularly thinking about patients and staff.	
• Benefits	This will mean a new way of working resulting in a more responsive approach to patients requiring ongoing periods of intervention. We should see a reduction in the amount of time staff are spending engaged in level 2 and 3 observations.
• Drawbacks	There may be challenges in implementing this in a high secure setting where positive risk taking is not always straightforward.
What potential unexpected consequences are there?	Reduction in use of staff to support increased observation levels should be realised.
Timeline - How long with this take to implement?	We have funding for 44 weeks so implementation will need to be done within this timeframe.
What resources will be required to support implementation?	An Oversight Group will be required to support the implementation. All other resources are already in place but may need to be used differently.
What are the savings that could be realised if this was rolled out across the hospital?	Reduction in staffing costs for increased observation levels.

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	We are looking to other boards who have successfully implemented IOP to understand any financial savings they have been able to attribute to this work.

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Service Transformation and Sustainability Project

Title: Nursing Resource Utilisation Project (NRU).

Description of proposed activity	**The NRU Project aims:** To put in place resilient systems that collect and report information on workforce and nursing resource utilisation and support its management. To deliver Business Intelligence reporting solutions that will provide data analysis and visualisation via interactive dashboards, and the dissemination of information across the hospital. **Current Status and Next Steps:** Agreed detailed data requirements in consultation with key stakeholders and by examining the paperwork and data flows for: • Rotas and rostering; • Managing availability and covering shift deficits; • Managing and resourcing clinical activity; • Sickness absence management; • Business Intelligence (BI) and the underlying data architecture. Conducted option appraisal of existing information systems and identified where any additional systems may be required. • We have confirmed that an e-Rostering system will be a solution to most of our requirements. There are several on the market but our preferred option is Allocate (used by a growing number of other Health Boards in Scotland). We are exploring routes to procurement. We have agreed in principle a collaboration with Lothian Health Board. We await with interest further information on a potential invitation to tender for a national e-Rostering solution, but will continue to explore the Lothian Health option until this is confirmed.

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	• We have purchased Tableau as our BI tool and we're working with National Services Scotland to implement it. We will be working with stakeholders to specify requirements for dashboards.
Who will be affected or impacted by the proposed activity? This may be directly e.g. the proposal may affect fewer than 10 patients and 50 staff directly and may impact on 25 patients indirectly.	An e-rostering solution is proposed. This will affect all nursing staff and nursing administrative staff. The Tableau Business Intelligence solution has been procured via National Services Scotland with 60 licences for our first phase.
What are we trying to achieve? - What is our theory of change? - what are we predicting will happen – by doing x we expect y – what changes can we make that will lead to improvement?	We have taken a structured systems analysis approach, working with key stakeholders through problem identification to articulate a clear set of requirements. We have formally appraised the options against these requirements. We will continue to apply the same rigour to the implementation of Allocate and Tableau, using PRINCE2 to ensure a successful implementation of these systems.
How will we know change is an improvement – what will we measure?	A Benefits Review Plan will be created. This will include the benefits to be measured, who is accountable for the expected benefits, how to measure achievement and when they can be measured, what resources are required to carry out the review work, and baseline measures from which the improvements will be calculated. It will be derived from the Business Case. The Business Case is scheduled for the August Board, depending on negotiations with Lothian Health Board and/or the outcome of the national e-Rostering tender. The implementation of these systems will not deliver improvements in isolation. The undernoted benefits can be achieved providing nursing leadership embed these systems within their directorate, develop working practices and business processes to ensure that live, accurate data is input and maintained, and that the decision support information yielded is utilised to analyse performance and take corrective action where necessary. **Anticipated benefits:**

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	• Operational efficiency. • Releasing time to care through more efficient roster production, shift deficit cover and data management –freeing nursing staff from administrative duties and back to clinical care. • Reduction in inappropriate skill mix (higher grades filling lower grade deficits). • Effective use of contracted hours (e.g. using all hours paid, no O/T when TIL owed). • Improved visibility of compliance, monitoring and acting on rule breakages (EWTD, too many nights, too many shifts, rest periods etc). • Live view of staff on site and whether staffing levels and placement is right to meet clinical demand. Right staff in the right place at the right time. Roster efficiency and safety. • Monitoring and managing planned versus actual care hours and costs, fill rate and cost by ward for ordinary/overtime hours, unfilled hours etc. • Ability to store patient numbers and patient dependency levels for each ward and shift, record care hours per patient day and calculate staffing levels from this information. • Better able to attribute reasons for overtime. • Enhanced capacity to cope with increased clinical demand. Being able to plan for the impact of increased patient dependency and other clinical activity pressures. • Increased capacity to cope with fluctuations in supply of nurses. Being able to plan for the impact of long-term absence, move away from very short-term management of deficit in shifts. • Better scheduling, distribution and management of all planned leave types over the year avoiding backlogs of A/L, training etc. • Better support for sickness absence management. • Better and fairer system for covering shift deficits. • Depersonalisation of decision making where appropriate. • Elimination of variation in rostering practice. • Increased reporting capability.

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	• Greater governance and auditing of data and processes.
Stakeholders and engagement – provide an overview of who has been involved in developing the proposal and how you have engaged, e.g. discussions, questionnaires, meetings etc	Requirements Analysis workshops and 1:1 meetings were held with Charge Nurses, Senior Charge Nurses, Nursing Administrative Staff, Lead Nurses, Clinical Services Manager, Director of Nursing, Director of Finance & Performance, Medical Director and the HR Director. The Chief Executive chaired the Project Board.
How will the proposed activity or intervention impact on:	
• Quality of care	• Arrangement of the right staff in the right place at the right time. • Releasing time to care through more efficient roster production and data management.
• Safety for staff and patients	• Releasing skilled clinical staff from arduous administrative duties and enabling them to deliver direct care will enhance safety for staff and patients. • Robust management of safe staffing levels.
• Cost of service	• A full cost reduction analysis has still to be completed. Other Boards report greater operational efficiency but have not released cost savings.
What are the benefits and drawback of proposed activity, particularly thinking about patients and staff?	
• Benefits	Anticipated benefits described above.
• Drawbacks	Disruption is possible in any transition to new systems and ways of working. We have experience of a good implementation from the PMTS system, and will use the lessons learned from that to minimise and mitigate against significant disruption.
What potential unexpected consequences are there?	None identified at this stage.
Timeline - How long will this take to implement?	It depends on negotiations with Lothian Health Board– the Directors of Finance and Nursing have approved a collaboration in principal, and the Allocate Programme Manager is keen to help. An exploratory meeting has been arranged for 30th July. Lothian

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	are also collaborating with Fife and Borders Health Boards. All additional Boards will need to be scheduled according to Lothians' resources. If the Lothian option does not work out, we may have to go to the market and issue a tender or await the outcome on the invitation to tender for the national e-Rostering solution (we have been advised that this will be issued in July).
What resources will be required to support implementation?	The resources are still being scoped out and will be detailed in the Business Plan as the project crystallises. There will be a cost for the collaboration with Lothian – software licences, SLA, a member of Lothian programme team working here to support our go-live. Alternatively, there will be cost for buying e-rostering software directly from the supplier. Our initial assessment is that the Allocate system can be run within existing Nursing Administration resources. There will need to be dedicated nursing representation on the Implementation Team – grade (s) and time to be determined. Given the increasing demand on eHealth Information Analysts and other projects such a RiO7 an additional Information Analyst will be required.
What are the savings that could be realised if this was rolled out across the hospital?	To be determined. Expected savings will be included in the Benefits Review Plan.

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THE STATE HOSPITALS BOARD FOR SCOTLAND

NHS SCOTLAND

Date of Meeting:	28 June 2018
Agenda Reference:	Item No: 8
Sponsoring Director:	Director of Nursing and AHPs
Author(s):	Director of Nursing and AHPs
Title of Report:	Safe and Effective Staffing Legislation
Purpose of Report:	For noting

1 SITUATION

The Health and Care (Staffing) (Scotland) Bill was introduced to parliament on 23 May 2018. The policy intention of the Scottish Ministers is to enable a rigorous, evidence-based approach to decision making relating to staffing requirements that ensures safe and effective staffing, takes account of service users' health and care needs and professional judgement, and promotes a safe environment for service users and staff.

The Bill will provide a statutory basis for the provision of appropriate staffing in health and care service settings, thereby enabling safe and high quality care and improved outcomes for service users.

This paper has been produced at this stage to ensure that the Board is sighted on the focus of this legislation, and the early stage action that will be required.

2 BACKGROUND

The Bill places a general duty to ensure appropriate staffing on Health Boards and care service providers. This requires them to ensure suitably qualified and competent individuals are working in such numbers as are appropriate for the health, wellbeing and safety of service users, and for the provision of high quality care.

These general duties on Health Boards and care service providers will not impose minimum staffing requirements or fixed staffing ratios as this would be at odds with the established policy approach in Scotland, and could potentially undermine innovation in service provision. The legislation will instead maintain local decision making and flexibility and support the ability to redesign and innovate.

For Health Boards, including Special Boards, this general duty to ensure appropriate staffing will be required in addition to a Health Board's existing duty in the 1978 Act, to put and keep in place arrangements for the purposes of workforce planning. The duty to workforce plan contained in 12I(c) will still exist and the general appropriate staffing duty in the Bill sets out more specific requirements – effectively 'levelling up' requirements on Health Boards to broadly mirror existing requirements on care service providers, making more explicit the requirements around the staffing element of workforce planning.

The Bill also includes a function for the Care Inspectorate to work in collaboration with the care sector to develop and validate appropriate methodologies and tools for care home settings for adults, in the first instance, with powers for Scottish Ministers to require use of such methodologies and tools and to extend the Care Inspectorate's function to cover other care settings in the future.

This general duty to ensure appropriate staffing will apply to Health Boards in relation to all their employees who deliver care, including but not limited to nurses, midwives, doctors, allied health professionals. The duty will also apply to clinical staff who work in services that are delegated to Integration Authorities.

In addition, where Health Boards commission services, consideration should be given to whether the provider of that service has appropriate staffing.

The intention of applying this general duty to all employees providing care is to ensure that one staff group is not protected to the detriment of other staff groups. Even if there is not currently a workload planning tool or methodology for a particular staff group Health Boards will still have to ensure appropriate levels of staffing for that group.

3 ASSESSMENT

The Bill will set out guiding principles, which must be taken into consideration when complying with the general duty. The guiding principles have been developed to ensure that staffing decisions across health and care service settings take account of key considerations. The principles set out that staffing decisions must also consider the needs of service users; the dignity and rights of service users; the wellbeing of staff; engagement with staff and service users about staffing decisions and effective allocation of staff.

For settings where a speciality specific staffing tool currently exists (as is the case for forensic mental health nursing), the Bill will make it explicit that Health Boards are expected to:

- Apply an evidence-based common staffing method, which includes the use of speciality specific staffing tools.
- Ensure that consideration of the output from the specialty specific staffing tool, professional judgement tool, local context and quality measures underpin and inform decisions about staffing requirements.
- Ensure a consistent approach to identification and mitigation of risk, seek and consider appropriate clinical advice and consider redesign opportunities.
- Ensure staff are appropriately trained to apply the common staffing method and tools, are engaged in the process, and have information relating to staffing decisions fed back to them.
- Monitor and report on how this has been done and provide assurance regarding safe and effective staffing.

It is important that having used the common staffing method described above that appropriate escalation and prioritisation processes are in place to support effective decision-making. Although these processes are not explicitly articulated in the Bill it is anticipated that existing governance structures within Health Boards will be used to support escalation of identified risk, review of mitigating factors and prioritisation of investment, where required, on a Health Board-wide basis. This will be clarified in future guidance on the Bill.

It is anticipated that future speciality specific staffing tools may take a more multi-disciplinary / multi-agency approach rather than applying to single staff groups, such as nurses and midwives.

The specialty specific staffing tools give information (not an answer) upon which discussions and debate can take place about nurse staffing establishments. A professional judgement tool is run at

the same time as the specialty specific staffing tools. This enables clinical staff to identify staffing requirements based on their own professional knowledge and understanding of the area and to identify justifiable additionality or reduction from current staffing for the workload during the time that the tools are run.

The local context in which the service is operating and measures and indicators of quality (which for nursing and midwifery will flow from Excellence in Care) to be taken into account when making decisions about staffing requirements. This is what is referred to as the triangulation process. By applying them on a regular basis and by using the triangulation process, Health Boards can make informed decisions when setting the budget for staffing in the relevant clinical area

This legislation will make it explicit that Health Boards are expected to apply the specialty specific staffing and professional judgment tools consistently, and for them to take account of the outputs along with information relating to local context, quality measures, and any concerns raised by staff when assessing staffing requirements. Alongside the Bill, guidance will set out that all of this information should be analysed and risk assessed against current staffing levels, any mitigating factors should be identified, appropriate clinical advice should be sought and appropriate escalation and prioritisation processes should be in place. In addition there will be a requirement to involve staff in the process and to ensure decisions made using the method are transparent and communicated to staff.

It is anticipated that robust application of the staffing tools and methodology will improve NHS Board projections on future staffing requirements. When used properly the tool and common staffing methodology enable services to be delivered in a more effective efficient way and support service redesign where required. Effective use of the tools and methodology can provide evidence upon which to redesign a service to suit the local context; to demonstrate use of funded establishment and additional hours such as bank staff; and to support a risk-based approach to decision-making. A refreshed Nursing workforce plan will be brought forward in 2018, using the methodology described in this paper.

It is anticipated that additional resource will be required to support Health Boards to consistently apply the methodology, to collate, analyse and report information across the organisation and inform transparent decisions about staffing requirements. The Scottish Government has already strengthened the Nursing & Midwifery Workload and Workforce Planning Programme infrastructure and will provide additional resource to support local boards to prepare for and implement requirements, based on exploration of areas of good practice. It is anticipated that we will require this support for approximately 2 years to allow processes to be embedded, including consistency of use of the speciality tools.

Healthcare Improvement Scotland (HIS) has previously been commissioned by the Scottish Government to develop nursing/midwifery specific quality measures for the Excellence in Care programme. This will provide a framework on which to measure and continuously improve quality in nursing and midwifery and will provide valuable information about the impact of nursing and midwifery staffing on the quality of care to be used as part of the common staffing method in conjunction with the staffing tool.

It is important that having used the common staffing method described above that appropriate escalation and prioritisation processes are in place to support effective decision-making. Although not set out in the Bill, it is anticipated that existing governance structures within Health Boards will be used to support escalation of identified risk, review of mitigating factors and prioritisation of investment, where required, on a Health Board-wide basis. This will be clarified in guidance and Scottish Government will be looking to work closely with key stakeholders to ensure this is appropriate and effective.

Once the Bill is introduced to the Parliament it will be assigned to a committee, for the Health and Care (Staffing) Bill it will be the Health and Sport Committee, The Committee's role is to consider and report to the Parliament on the general principles of the Bill – that is, on the principal purposes of the Bill, rather than the fine detail.

The Committee is likely to issue a call for written evidence from any interested stakeholder at the beginning of the inquiry. The lead Committee is likely to consider different methods of gathering evidence from those who are likely to have an interest in the Bill or be affected by its provisions. The Committee will normally also take oral evidence from a range of witnesses over a number of meetings before publishing a Stage 1 report on the Bill.

The parliament will then debate the general principles of the Bill and decide whether to agree to them. If the parliament votes in support of the Bill the Bill then passes back to the Committee for Stage 2. The principal role of the Stage 2 Committee is to consider and dispose of amendments to the Bill. Once amendments have been considered an updated Bill is published and considered at Stage 3.

Stage 3 takes place at a meeting of the whole Parliament. Stage 3 is in two parts: proceedings to debate and disposal of those amendments (if any) selected for debate; and a debate followed by a vote on whether the Bill should be passed.

4 RECOMMENDATION

The Board is asked to **note** this update on safe and effective staffing legislation. An update will be provided when this has progressed through the parliamentary process described.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Draw's Board's attention to future legislative requirement as it relates to staffing. This in turn will help ensure the delivery of safe, effective and person centred care.
Workforce Implications	Sets out requirement for WFP methodology to be used as part of future legislative requirement.
Financial Implications	No implications identified at this stage
Route To Board Which groups were involved in contributing to the paper and recommendations.	Via Director of Nursing/AHPs
Risk Assessment (Outline any significant risks and associated mitigation)	Not assessed.
Assessment of Impact on Stakeholder Experience	Not assessed.
Equality Impact Assessment	Not assessed.

NHS SCOTLAND

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	28 June 2018
Agenda Reference:	Item No: 9
Sponsoring Director:	Director of Nursing and AHPs.
Author(s):	Jacqueline Garrity, Skye Centre Manager
Title of Report:	Skye Centre Annual Board Report
Purpose of Report:	For information and noting

1 SITUATION

This report provides an update on patient activity services within the Skye Centre. It details service activity levels for the period June 2017 to May 2018. Key pieces of work undertaken and future developments are also highlighted within the report.

2 BACKGROUND

The Skye Centre service has experienced a number of vacancies over the past year with the fluctuation in the staffing resource directly impacting on the delivery of activities. The Skye Centre also supported the actions related to the Financial Recovery Plan during February, March and the first few weeks in April 2018 by providing 4 members of staff to each Hub on a morning and afternoon basis, and 2 at the weekends. This significantly impacted on the delivery of activity during this period. However despite these challenges the staff group remained dedicated and professional in their approach and the flexibility they demonstrated each day minimised the impact on the existing activities, enabling them to still deliver a quality service to patients.

3 ASSESSMENT

The content of the annual report includes an update on the progress of the previous year's recommendations and provides information on following areas as these pertain to the Skye Centre Service :-

Governance & Management Arrangements
- Governance Arrangements
- Management Arrangements

Key Performance Indicators
- Safe
- Effective
- Person Centred

Key Pieces of Work Undertaken During the Year
- Vocational Qualifications/Courses
- Patient Active Day
- Review of Supervision Model

- Sickness
- Social Events
- Carer Involvement

Identified Issues and Potential Solutions
- Recruitment
- Redesign of Woodwork Space

4 RECOMMENDATION

The Board are invited to note & endorse the following areas of work and potential service developments as described within the content of the report :
- Redesign of Woodwork Space
- Patient Active Day
- Activity Scheduling
- Supporting Health Choices
- ONELAN
- Outcome Measures
- Evening Social Activities
- Recruitment
- Efficiency Savings Targets

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	
Workforce Implications	None
Financial Implications	None
Route To Board Which groups were involved in contributing to the paper and recommendations.	SMT
Risk Assessment (Outline any significant risks and associated mitigation)	None identified
Assessment of Impact on Stakeholder Experience	Stakeholders view taken into account when considering content of this report
Equality Impact Assessment	Not applicable

THE STATE HOSPITAL BOARD FOR SCOTLAND

SKYE ACTIVITY CENTRE

BOARD ANNUAL REPORT

June 2017 – May 2018

Reference Number		Issue:
Lead Author	Jacqueline Garrity, Skye Centre Manager	
Contributing Authors	Tracy Tait, Skye Centre Secretary	
Approval Group	The State Hospital Board	
Effective Date	June 2018	
Review Date	May 2019	
Responsible Officer (e.g. SMT lead)	Mark Richards, Nursing & AHP Director	

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- Safe
- Effective
- Person Centred

Section 4 – Key Pieces of Work Undertaken During the Year

- Vocational Qualifications/Courses
- Patient Active Day
- Review of Supervision Model
- Sickness
- Social Events
- Carer Involvement

Section 5 – Identified Issues and Potential Solutions

- Recruitment
- Redesign of Woodwork Space

Section 6 - Future Areas of Work and Potential Service Developments

- Redesign of Woodwork Space
- Patient Active Day
- Activity Scheduling
- Supporting Health Choices
- ONELAN
- Outcome Measures
- Evening Social Activities
- Recruitment
- Efficiency Savings Targets

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Appendices

Section 1 – Introduction

This report provides an update on patient activity services within the Skye Centre. It details service activity levels for the period June 2017 to May 2018. Key pieces of work undertaken and future developments are also highlighted within the report.

The Skye Centre service has experienced a number of vacancies over the past year with the fluctuation in the staffing resource directly impacting on the delivery of activities. The Skye Centre also supported the actions related to the Financial Recovery Plan during February, March and the first few weeks in April 2018 by providing 4 members of staff to each Hub on a morning and afternoon basis, and 2 at the weekends. This significantly impacted on the delivery of activity during this period. However despite these challenges the staff group remained dedicated and professional in their approach and the flexibility they demonstrated each day minimised the impact on the existing activities, enabling them to still deliver a quality service to patients.

2017/18 Recommendations Update

Comparison with last annual report

Recommendation Description	Achieved/Not Achieved	Comments
Workforce Review/Efficiency Savings Targets For the financial period 2017/18 the agreed savings target is £34k. The necessary steps have been identified to meet the agreed savings target with £20k being identified as recurring savings.	Achieved	The Skye Centre Service exceeded the savings target identified for 2017/18 and also achieved the £20k recurring saving target.
Sustainable Work Force/Succession Planning In the workforce planning recommendations set out and implemented within the Hubs, it was stated that clarity regarding the ward level Nursing leadership structure could be realised through the phasing out of our current Senior Staff Nurse role at band 6, and the implementation of a revised Team Lead structure.	Achieved	The Workforce Planning process was concluded and an outcome of this was to increase the number of Band 6 Charge Nurse posts across the service. An additional Charge Nurse was appointed in April 2018.
Equity of Access to Interventions As part of the Patient Day Development group a short life working group has been established to consider the referral process between the Hubs and Skye Centre and to identify available options for scheduling an agreed level of activity for patients to engage in	Achieved	The Skye Centre Induction and Sports & Fitness Induction were reviewed and implemented in June 2017. Both pathways were reviewed again in April 2018 taking on board feedback re the process and the updated processes were implemented in May 2018. Progress is reported to the Skye Leadership Group.

Recommendation Description	Achieved/Not Achieved	Comments
Patient Active Day Project The Active Day model, will involve, in the first instance one ward (Lewis 2) closing, with the patient group spending their day in the Skye Centre. This will support greater access to activity for this specific group of patients, and will also provide an opportunity to deploy staffing in a way that best meets delivery of activity in the Skye Centre and in the Hubs.	Achieved	The Lewis 2 project commenced in June 2017 and is currently still in place 1 day per week.
Supporting Health Choices Consultation Discussions are presently taking place regarding how the focus of the service can be adapted to promote a more integrated service with the Sports & Fitness staff which in turn will support the Health Choices agenda	Achieved	Active day model was agreed and was implemented on 20th June 2017, with focus on increasing capacity in sports. Lewis 2 have continued to attend the Skye Centre one day per week. Patients access the Sports & Fitness along with participation in the other activity centres also.
Review of Supervision Model Discussions are planned with our practice development colleagues regarding appropriate models of formal clinical supervision for this staff group.	Achieved	Group supervision commenced in November 2017 and is facilitated by the Practice Education Facilitator and given the size of the staff group involved it was agreed that supervision would be provided on a monthly basis however staff are expected to attend 6 group supervision sessions throughout the year.
Using Data and Gathering Outcomes The importance of gathering evidence of impact and clinical outcomes remains an area that requires further development. The Induction Programme and Gardens & Animal Assisted Therapy have been identified as the pilot areas.	Not Achieved	The Induction Pathway was reviewed and now includes joint working with the relevant OT and the completion of the OT assessment tools to inform the patient needs. The revised pathway was introduced in May 2018. The review of the Gardens Activity Centre will hopefully inform an appropriate assessment method for use in this area.
Redesign of Woodwork Centre In April 2017 the SMT approved the option to close the Woodwork and redesign this area into a generic therapeutic space in which a range of planned individual or group activities can be facilitated by a range of	Not Achieved	There have been delays in modifying and clearing the room however there has been good progress made within the past month. In order to progress with the proposed change in practice, further work and discussion requires to take place with the H&S Committee and SMT

Recommendation Description	Achieved/Not Achieved	Comments
professionals		to take forward the recommendations for the Skills Mix Review which will support an integrated multi-disciplinary model to facilitate groups. The Skye Centre Manager has prepared an SBAR for discussion at both forums.

Overview

The Skye Centre service is defined by four Activity Centres, and also includes the Atrium where the patients can access the activity group room, café, library, shop and bank. There are also a variety of other groups facilitated in this environment by the Involvement & Equality Team (Patient Partnership Group - *PPG*, Christian Fellowship and Multi Faith Services), the Psychological Therapies Service and Allied Health Professions staff. The Advocacy service also host their annual AGM and strategic meetings in the Skye Centre both of which include patient representation. It is also important to note that the Health Centre is an integral part of the service and operates closely with the wider activity centres and Atrium.

Service Delivery

Staff configuration
The Skye Centre service consists of a group of registered Nursing staff, supported by skilled technical staff and Health Care Support Workers, who are all dedicated to meeting the clinical, educational, health & wellbeing, vocational and recreational needs of our patient population.

The Skye Centre staffing establishment is presently 38.33 wte, the actual staff in post is 34.83 wte due to vacancies. The service is currently operating with 4 vacancies (3.5wte), one of these staff members is currently on secondment until October 2018. An additional long standing member of staff is due to retire in October 2018. The recruitment process is ongoing for these posts. Adjustments have been made to internal staff deployment across the service to mitigate against the temporary loss of these posts.

<u>Volunteers</u>
The Skye Centre service continues to work alongside the Involvement & Equality Team to support the role of volunteers across the service. The number of volunteers has decreased from 8 to 4 over the last 12 months with a number of our Volunteers taking up new opportunities out with the State Hospital. The recruitment process successfully identified 3 new Volunteers for the Crafts and Gardens activity centres and the induction process is underway for this group. A further interview date has been scheduled for Monday 25th June to recruit a Volunteer for the Gardens and further recruitment is being planned to recruit an additional Volunteer for the Sports & Fitness. There are also five volunteers who help facilitate the Spiritual and Pastoral Care Team by attending the weekly Christian Fellowship group held in Skye Centre.

The Skye Centre service operates Monday to Friday with sessions available morning and afternoon, with activity also available on a Saturday and Sunday - evening activities are provided on 2 of the 6 Saturday evenings within the 6 week shift rota. Skye Centre staff continue to be supported by Hub based nursing staff to provide weekend and evening activities.

The Health Centre is appropriately resourced within the current staffing establishment. However from within the team the service supports and accommodates one member of staff to participate in regular Staff Side duties and weekly Public Duties for which there is no budget arrangement in place to provide backfill for service delivery. Whilst it is often successfully accommodated, it can prove a challenging task to balance the staffing requirements and reallocate the existing staffing resource to minimise the disruption of the activities on offer to patients.

Delivery of Interventions

There are a wide range of group interventions available to the patient group attending the Skye Centre. The range of groups on offer are defined under the following categories, these are:-

- Crafts & Creative Expression
- Education & Learning
- Life Skills
- Physical Health & Fitness
- Recreation
- Mental Health & Recovery
- Vocation & Working Activities

The interventions are available at varying degrees of complexity to meet our patient needs and are delivered in a variety of formats. There are regular ongoing group activities such as the animal care, crafts or sports and general learning sessions for which there is no restricted time limit. The scope of these activities will be modified depending on the needs of the patients participating. In contrast to this there are a number of planned, time limited groups such as SVQ qualifications i.e. Sports Leadership, Creative Arts. Patients are approved to participate in these group activities after discussion with their respective Clinical Teams. The Crafts staff also work collaboratively with the Art Therapist delivering group interventions in the Craft & Design Centre.

Section 2 - Governance & Management Arrangements

Governance Arrangements

Formal reports on Skye Centre activity are reported on an annual basis to The State Hospital (TSH) Board and the service is represented at this group by the Nursing & AHP Director. Strategic aims and priorities for Skye Centre activity levels are monitored on an ongoing basis by the Skye Centre Manager who reports to the Clinical Operations Manager. Approval for new developments and initiatives are discussed and generated through the Skye Centre Leadership Group which meets monthly and further approved by the Senior Management Team at which the Skye Centre service is represented.

Management Arrangements

The Skye Centre Manager is operationally responsible for the Skye Centre service and staff group. The Senior Charge Nurse is managerially responsible for the group of nursing staff. In line with the recent Skye Centre Nursing Workforce review carried out in 2017 the service now operates with 3 Charge Nurse posts each with responsibility for the day to day supervision of discrete areas of the service.

Section 3 - Key Performance Indicators

Figures : The Local Delivery Plan targets for activity are and set out as key performance indicators (KPI's) 2016-17 and comparison with previous 3 years

Performance Indicator	Target	17/18	16/17	15/16	14/15	13/14
Patient will be engaged in off-hub activity centres	90%	79%	83%	81%	73%	79%
Patients will undertake 90 minutes of exercise each w (Annual Audit)	60%		-	-	-	66%
Patients will engage in meaningful activity on a daily b	100%		-	-	-	-
Attendance by all clinical staff case reviews	-	54%	59%	59%	60%	63%

The LDP targets are underpinned by a number of supporting measures, including:

- Provision of reports for annual review meetings
- Patient Learning Outcomes
- Attendance at clinical supervision

Safe

The nursing staff within the Skye Centre service receive clinical supervision in line with the nursing supervision model that has been agreed and approved within the organisation. Over the past 12 months all Skye Centre registered nursing staff received formal supervision - 4 staff members participated in individual supervision and 5 staff members participated in monthly group supervision facilitated by a Clinical Nurse Specialist allocated from the Psychological Therapies Service.

Our support staff participate in group supervision facilitated by a member of the Nurse Practice Development Team.

There has been a decrease in the number of Health and Safety incidents reported involving the Skye Centre over the last 12 months from 123 to 86. Figure1 below outlines the number of incidents recorded in comparison with the previous year.

The delivery of activities across the service continue to be risk assessed and modified to ensure that patients have access to the necessary resources, tools and equipment at a level appropriate to their needs i.e. induction sessions, low tool and tooled sessions.

Figure1 Skye Centre H&S Recorded Incidents by Category

Incident Category	1 Jun 2016 - 31 May 2017	1 Jun 2017 - 31 May 2018
Assault	3	2
Attempted Assault	3	3
Behaviour	18	12
Breach of Patient Confidentiality	3	1
Breach of Staff Confidentiality	0	1
Breaches	14	10
Contact	6	3
Damage	2	0
Equipment Malfunction	5	3
Exposure	2	0
Injured by animal	3	0
Keys	1	2
Moving & Handling	1	0
Other	10	6
Sexual	4	2
Slip/Trip/Fall - Patient	12	10
Slip/Trip/Fall - Staff/Other	1	1
Staff/Patient Injury	19	12
Staff Resource Issue	5	0
Struck	2	3
Verbal aggression/abuse	9	12
Totals	**123**	**86**

Effective

The progress of individual patients is monitored in a number of ways. This can be achieved subjectively using non standardised methods such as observation of behaviours, interactions with peers/staff and the recording of staff clinical reasoning and judgement, documented using the electronic patient record (RIO).

There are presently a range of Patient Learning Outcomes and KPI's in place across the service and these are reported annually in a separate report to the Board. This report was received in February 2018 and detailed the progress made and the recommendations related to patient learning for the coming year. It is important to note that these outcomes related to patient learning are an integral part of the Activity Centres and support the selection and development of the patient timetable.

Skye Centre staff continue to attend weekly Clinical Team meetings and Annual CPA Review meetings as and when the clinical need is indicated.

During the period of the report there were 100 annual reviews and the Skye Centre VAT form completion was 100%. Figure2 below outlines the ICP data for the previous year.

Figure2 Skye Centre ICP DATA June 2017 – May 2018

Treatment & Rehabilitation VAT	**N = 100**
Skye Centre report available	72% (72)
Those not done	
Case Review date changed	1
No reason	1
No SAC placements	25
	1
Patient unsettled presentation	
Admission VAT	**N=22**
Admission Fitness Assessment completed	45.5%(10)
Those not done	
Joint Admission/Discharge CPA	2
No reason	3
Patient unsettled presentation	6
Not referred by CTM	1
Day of Discharge Report	**N=31**
SAC Patient Learning Information	45.2%(14)
Those not done	
Discharge to court	3
No reason	0
No SAC placements	9
Patient transferred overseas	1
Not applicable	4
SAC Activity Centre Reports	45.2%(14)
Those not done	
Discharge to court	3
No reason	0
No SAC placements	9
Patient transferred overseas	1
Not applicable	4

Skye Centre nursing staff attendance at annual case reviews was recorded at 0%. This has been a continual downward trend over the past few years. This matter was raised at the May 2018 Clinical Governance Group along with other disciplines' reduction in attendance. Whilst the benefit of nursing staff attending the CPA review is widely acknowledged, the staffing is prioritised to ensure that activity centres remain open. It was agreed that the Skye Centre figures would not be recorded for the purpose of the VAT going forward however the information will still be collated and provided to the Skye Centre Manager for the purposes of monitoring the service.

The Skye Centre sections of the Admission Vat were recently reviewed to reflect the amendments to the Induction Pathways and were implemented in April 2018.

Person – Centred
The Skye Centre service has made every effort to comply with the principles outlined in the revised NHS Complaints & Feedback Procedure and staff have been encouraged to act on all feedback effectively, resolving issues as early as we can, and learning from them where we can so that we can improve our service.
There has been a decrease in the number of formal complaints from patients regarding the Skye Centre within the last 12 months. Figure3 below outlines the number of complaints received during the reporting period. A total of **11** complaints were received (4 upheld, 1 partially upheld, 4 not upheld, 2 withdrawn) in comparison to **16** during the previous year (11 upheld, 2 partially upheld, 3 not upheld). Appendix 1 provides further detail for each complaint.

Figure3

Skye Centre Complaints	**1 June 2017 - 31 May 2018**
Stage 1 Complaint	6
Stage 2 Complaint	3
Escalated to Stage 2	2
Total	**11**

In previous years a number of complaints have been received from patients regarding access to services and centre closures. There were 6 complaints received in relation to this over the past year a reduction from 13 received during 2016/2017. It is important to note that 3 of the complaints received were during the Financial Recovery period during the last financial quarter. During this period the Skye Centre were providing 4 staff morning and afternoon to the Hubs. Every effort was made during this period to redistribute the staffing resource to minimise the impact on patients' placements.

'What Matters to You' Campaign: 6th June 2017

The Skye Centre Team, supported by the Involvement and Equality Lead, facilitated the 'What Matters to You?' session on the afternoon of 6 June. The group reflected on the two questions detailed below in relation to each activity area, from which a focused discussion took place to identify common themes, following which priority actions were developed.

- "When you have a good session at your placement, what are the things that make it good?"
- "If your session has not gone so well, what do you think would have made it better?"

Patients with significant barriers to communication were supported to share their views, eliciting some insightful comments. The Involvement & Equality Lead has stated that the feedback from patients, staff and the volunteer who attended has been very positive. She fedback that:

"There was a real buzz in the room, with some great conversations taking place – patient involvement in its truest sense, and even more significant given the nature of our care setting. The experience was a really collaborative process and, as a result, empowered everyone present to have a say".

Action plans from the event helped inform service developments and informed practical changes within individual activity areas e.g. relocating furniture to enhance the learning experience within the PLC, recognition and further development of the 'Buddy' system within the Gardens activity centre.

Plans are in place to hold this event again in June 2018 for this year's 'What Matters to You' day using the same format however the discussions will be extended to include our Volunteer group and Health Centre.

Table 4 below provides detail of the number of planned sessions over the past 5 years in comparison to the actual number of sessions attended. The number for both planned sessions and actual attendances has decreased over the past 12 months. This can be attributed to staffing resource issues and centre closures.

Table 4:

	Scheduled Interventions	Number of interventions attended	% between planned and attended
2017/17	**19187**	**14669**	**23%**
2016/17	21212	18938	11%
2015/16	24032	19076	21%
2014/15	22712	16798	27%
2013/13	23068	15255	34%

A summary of the reasons for non-attendance over the past 12 months are detailed in Figure 5 below. Overall the figures related to non-attendance have increased. The centre closures and weather conditions have had the most impact on non-attendance over the past year. The number of non-attendances related to patient refusal has also increased.

Table 5:

Reasons for on attendance at Scheduled session	**2017/18**	**2016/17**	**2015/16**	**2014/15**
Deterioration in Mental Health	652	615	578	679
Physical Health Problem	479	521	518	765
Appointments with other Health Care Professional	589	534	429	517
External appointments	133	148	500	805
Tribunal/CMT/CPA Appointments	40	51	58	65
Patient refuses to attend	751	512	481	501
Service Closed/Reduced Service	2368	2112	1511	1253
Patient seeing external visitor	30	14	79	94
Visit on ward	211	300	109	315
Discharge/Transfer/rescheduled sessions	249	277	219	101
Bad Weather	637	104	45	69
Other	786	417	354	463
Attending other Skye Centre activities using Drop in	173	293	75	287

New Admissions - Access to Skye Centre

The proposal to introduce the Induction Pathway and Sports Induction Pathway was approved by the SMT in April 2017 and was implemented in June 2017. There was a further review of both pathways in April 2018 taking on board feedback regarding how this process could be further improved. Appendices 2a/b includes two case studies which provide further detail on the steps taken by staff to complete the induction pathways.

The Skye Centre Induction Programme takes place twice a week over a 4 week duration. This group consists of new admission patients and 'hard to reach' patients with no current placements.

The Sports Induction Programme consists of a Hub Gym Induction, Sports Fitness Assessment and 2 weekly Admission Sessions in Sports. This is provided to new admission patients. (Hard to Reach patients are accommodated at an alternative time)

27 patients were admitted from June 2017 to May 2018.

Sports Induction Pathway

All admitting wards were contacted within 48hrs from admission to arrange suitable times to attend the wards to meet the patient and carry out Hub Gym Induction and to arrange a suitable appointment for a Sports Assessment to be carried out in the Sports Department.

From the 27 patients admitted during this period, on the advice of the ward nursing staff, 4 patients currently remain too unwell to participate in a Hub Gym Induction. Unless informed otherwise, the Sports staff contact the ward every 14 days to review the patient's suitability to participate in the Induction process.

Over the last 12 months it has taken on average around 40 days from admission for a patient to complete the initial stage of the Sports Pathway i.e. Hub Gym Induction in comparison to 67 days the previous year. The reasons for this delay can be attributed to the patients' poor mental health and presenting challenging behaviours. As a consequence the other stages of the pathway are unable to be progressed. The Sports staff have maintained fortnightly contact with the ward nursing staff to ascertain all of the patients' suitability to attend. This information is recorded on the Sports Database.

From the 27 patients admitted, on the advice of the ward nursing staff, 9 patients currently remain too unwell to attend the Sports and Fitness Activity Centre to commence the physical assessment and attend planned weekly Admission sessions. Unless informed otherwise, the ward are contacted every 14 days to review individual patient's suitability to engage in the Sports Induction programme.

Over the last 12 months it has taken on average around 67 days from admission for a patient to attend the Sports and Fitness Department to participate in the assessment process. The reasons for this delay can be attributed to the patients' poor mental health and presenting challenging behaviours.

Skye Centre Induction

Of the 27 patients admitted, 14 patients did not / have not completed an Induction programme to date. (4 patients were discharged before commencing the Induction and 10 remain too unwell to attend). Unless informed otherwise, the Atrium staff contact the ward every 14 days to review the patient's suitability to participate in the Induction process.

Over the last 12 months it has taken on average around 107 days from admission for a patient to commence an Induction programme. The reasons for this delay can be attributed to the patients' poor mental health and presenting challenging behaviours. However it also became apparent that delays were being encountered due to not receiving a referral form from the CTM. As a result the Induction Pathway was reviewed and amended in April 2018 to remove this stage as a requirement in the process.

Referrals –

Referrals are received from the CTM for patients to attend a range of activities provided by the Skye Activity Centres. In comparison the previous 12 months there has been a decrease in both the number of referrals and the number of patients this relates to. Figure 6 below provides the referral data for the previous 3 year reporting period.

Figure 6 Number of Referrals

	No. of referrals received	No. of patients
2017/18	93	61
2016/17	170	117
2015/16	136	58

Figure 7 below provides the number of referrals received from each hub following discussion and approval from the respective Clinical Teams.

Figure 7

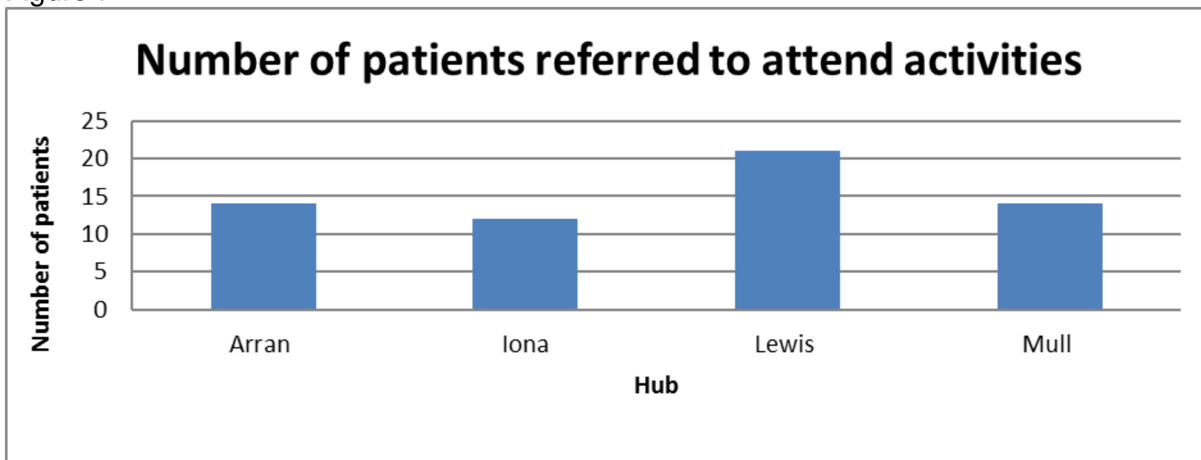
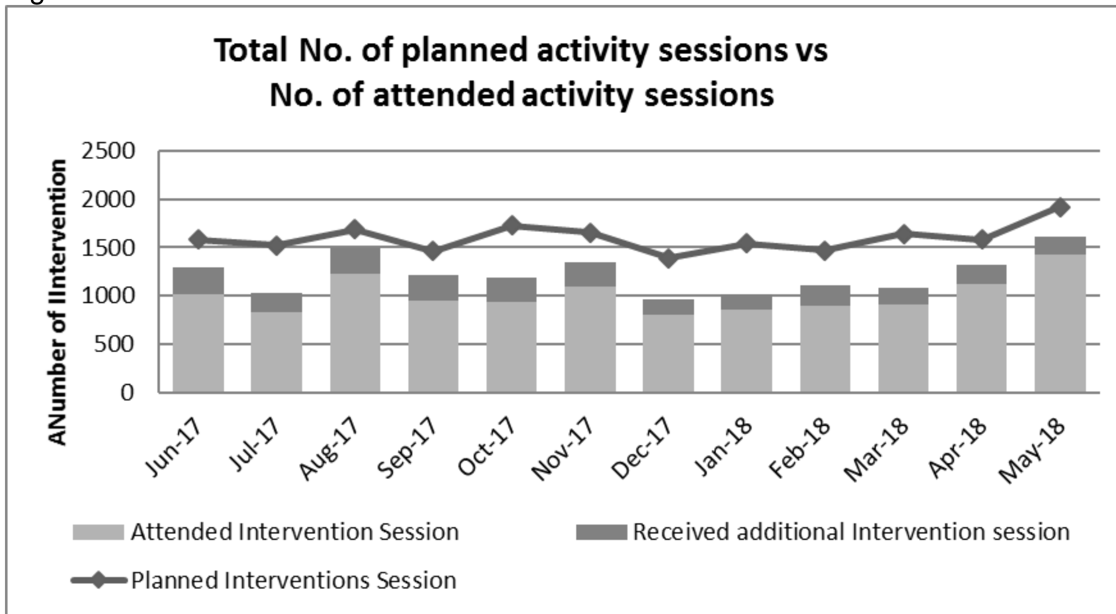


Figure 8 below details the number of activity sessions patients engaged in at the Skye Centre for the period June 2017 to May 2018.

There are currently 84 patients (79%) with planned activity sessions at the Skye Centre (data related to week commencing 28th May 2018). This is in comparison to 91 patients (83%) in 2017. The patient engagement can range between 1 session and 10 sessions. On average patients have 5 sessions per week.

Figure 8



The number of actual attendances decreased in July 2017, which can be attributed to an increase in the number of closures during that month (n=29), related to vacancies and staff sickness and the additional pressure of July being a high peak holiday period. The decrease in the figures for December, January, February and March can be attributed to staff sickness, inclement weather conditions, other events (i.e. Ward Christmas parties) and the contingency measures put in place for the Financial Recovery Plan.

Figure 9 provides an overview of the planned activity for each Activity centre and the actual attendance by patients during the period June 2017 to May 2018.

Figure

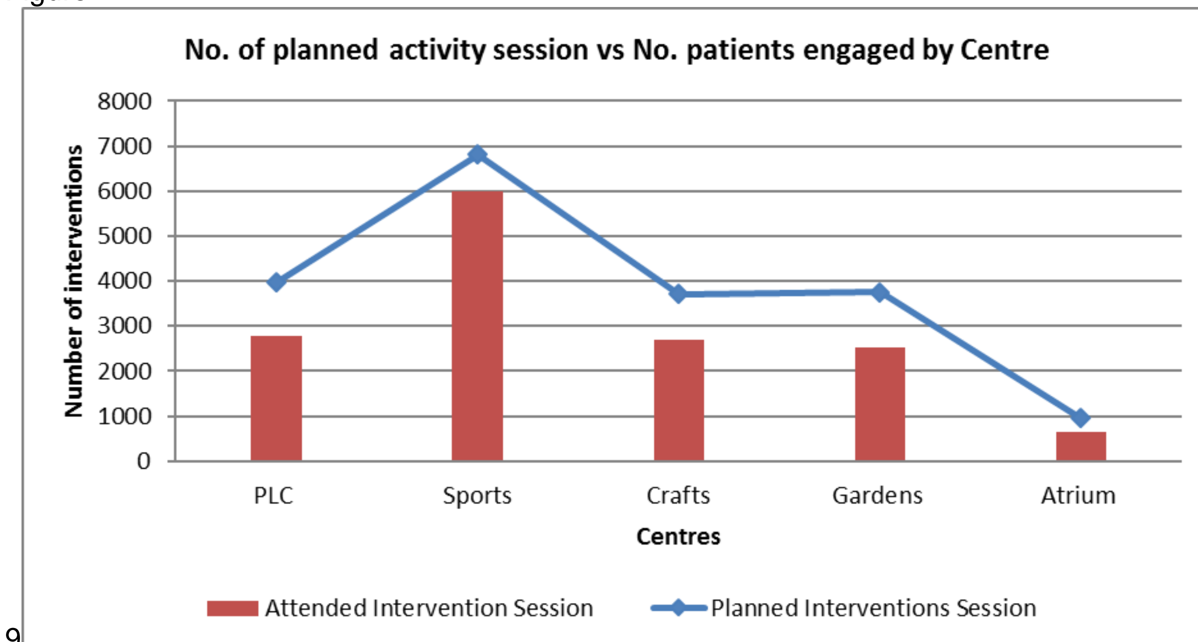


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Figure 10 provides information related to the caseload and waiting list for each activity centre. The 1 patient waiting for a placement in Gardens does have placements within the PLC however due to the complex needs of this individual and requirement for increased staffing and tailored interventions, ongoing discussions are taking place with the Clinical Team to coordinate and facilitate a suitable time to attend.

Figure 10

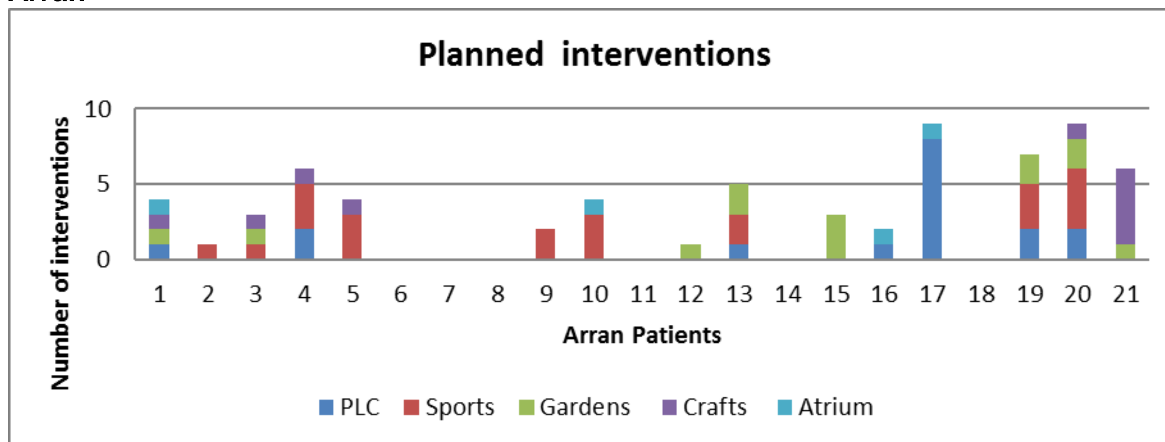
	No. of patients participating		No. of patient on waiting list	
	2016/17	2017/18	2016/17	2017/18
PLC	36	37	0	0
Sports	64	55	0	0
Crafts	45	38	0	0
Gardens	40	43	3	1
Atrium	15	28	0	0

Many patients attend more than one activity centre and they may be involved in individual tasks or participate in group projects.

The following charts demonstrate the range of Skye Centre activities that individual patients are scheduled to attend. It is evident that each hub varies in relation to individual patient engagement at the Skye Centre and across each activity centre. The data presented is reflective of the patients' weekly Skye Centre timetable and does not include the time spent attending the Health Centre which varies or Patient Shop which the majority of patients attend one morning per week. It also does not include groups facilitated by the Involvement and Equality.

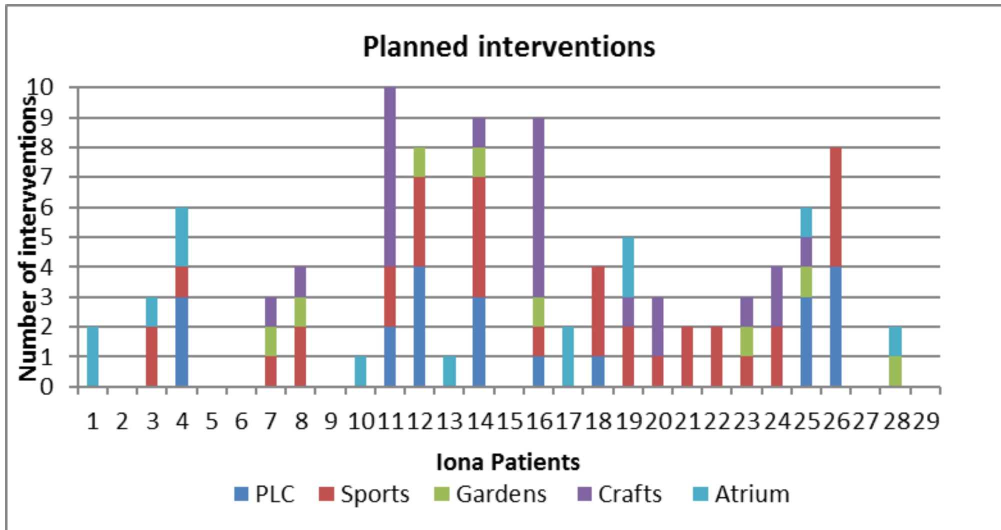
The number of activity sessions patients attend are recorded over the period 9am – 4pm Monday to Thursday and 9am – 3pm on a Friday. The patients normally attend for a full morning session and the afternoons are currently split into two sessions with patients having the option to stay at the Skye Centre all afternoon.

Arran



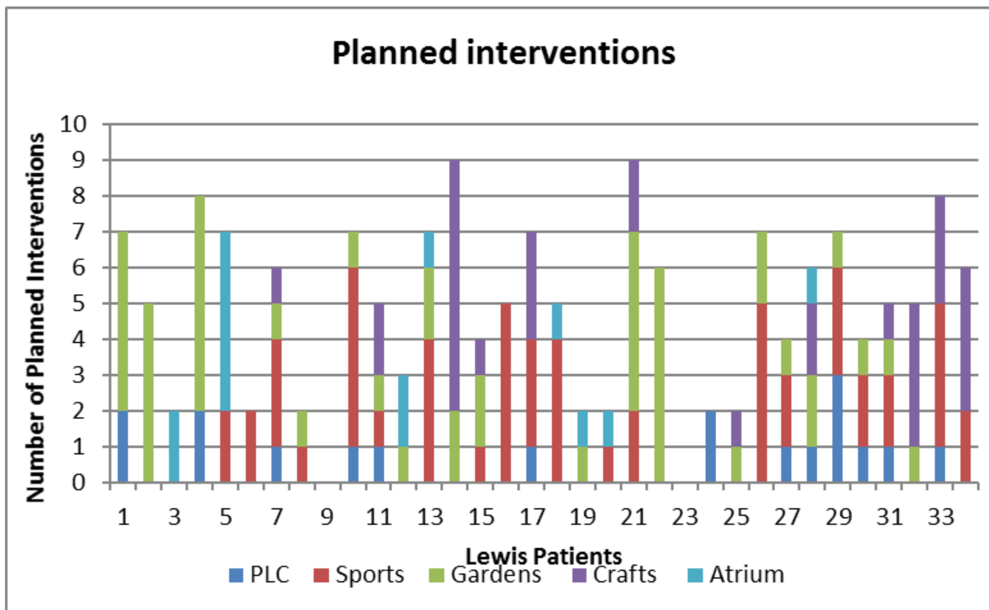
From the 6 Arran patients with no planned interventions at the time of report; following fortnightly discussion with the CTM 2 patients mental health remains too poor to engage in activity at the Skye Centre. The remaining 4 patients refuse to attend any planned interventions, however do use the drop in facility within the Atrium.

Iona



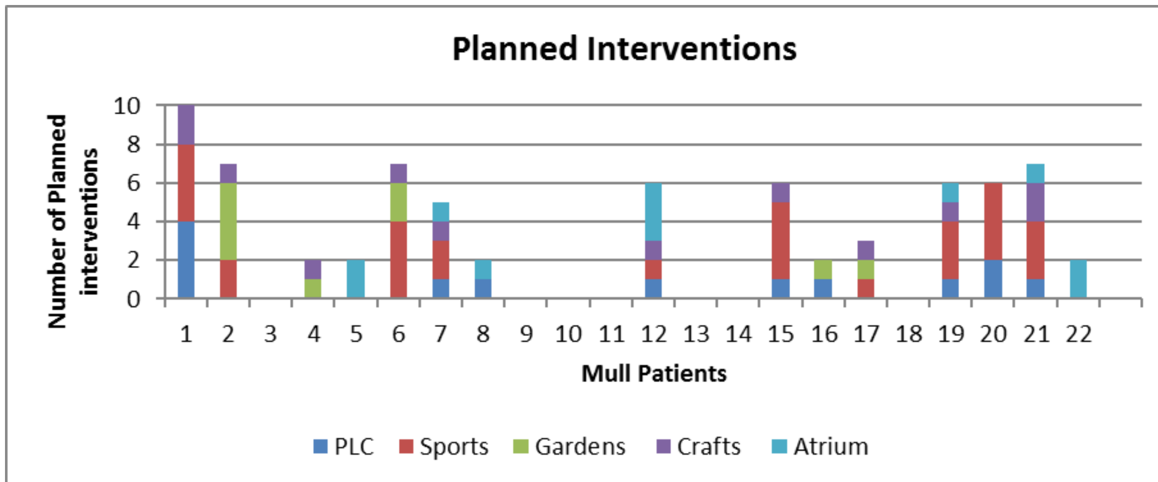
From the 7 Iona patients with no planned interventions at the time of report; 2 patients are new admissions. The feedback received from the CTM is that both patients are not suitable at present to attend any planned intervention at the Skye Centre. 4 patients do not attend due to their poor mental health. Fortnightly communications take place with Skye Centre staff and the CTM around the suitability for these patients to attend. 1 patient currently refuses to attend any planned intervention.

Lewis



From the 2 Lewis patients with no planned intervention; 1 patient is a new admission and the feedback received from the CTM is that this patient is not suitable to attend any planned intervention at the Skye Centre at the present time. Fortnightly communications take place between the Skye Centre and the CTM to review this. The remaining patient that has no planned interventions refuses to attend despite ongoing encouragement from both ward and Skye Centre staff.

Mull



From the 7 Mull patients with no planned intervention; 4 patients are new admissions and the feedback received from the CTM is that these patients are not suitable at present to attend any planned intervention at the Skye Centre. Fortnightly communications take place between the Skye Centre and the CTM to review this. 1 patient does not attend planned sessions at this time due to their poor mental health, however does attend on a drop in basis. 2 patients refuse to engage in planned sessions, although one of these patients does attend the Skye Centre for drop in activity at the Atrium.

Section 4 – Key Pieces of Work Undertaken During the Year

Patient Active Day Project

The purpose of this new Active Day model was to create a different focus to service delivery that maximises opportunities for therapeutic activity across the site, makes best use of our activity and staffing resources, and which also has the potential to deliver a clearer sense of progression for our patient group.

The Lewis Project involved, Lewis 2 closing one day each week, morning and afternoon, with the patient group spending their day in the Skye Centre. This provided greater access to activity for this specific group of patients, and also provided an opportunity to deploy staffing in a way that best meets delivery of activity in the Skye Centre and in the Hubs.

This model allowed us to create more capacity within the Skye Centre, minimise departmental closures in Sports, and our staff also reported positively on their work experience during this time.

An improvement cycle approach was developed to monitor and support modifications to the model as it progressed.

Each morning and afternoon 2 Lewis ward staff are deployed to the Skye Centre when the patients attend for their morning and afternoon sessions, and they work within the Skye Centre throughout the session. Staff have been inducted and trained to support them in this role. There has been high Clinical activity within Lewis Hub during this change however both the Skye Centre and Lewis nursing teams have worked in a collaborative and flexible way to ensure the staffing resource in made available to support this initiative.

The Patient Active Day Group agreed to replicate what has been achieved in Lewis 2 and the Active Day model for patients in Iona 2 was introduced in March 2019. In order to accommodate this specific group of patients the model was varied with 3 patients remaining on ward due to their individual treatment needs and the remaining patients attending the Skye Centre morning and afternoon over 4 days. The number of staff deployed to attend with the patients varies between 1 and 2 each session depending on clinical activity.

Vocational Qualifications/Courses

Patient learning programmes are an integral part of the Skye Centre service with our Senior Rehabilitation Instructors and Education & Learning Officers responsible for the delivery of patient learning programmes. The objectives and progress made in this area over the past year has been outlined in the recent Patient Learning Annual Board report received in February 2018.

A range of themed learning courses have taken place during the period of reporting – The 'Tour de France' group was a joint initiative between the Patient Learning Centre and Sports & Fitness Centre incorporating the Bikeability programme, and the 'Culture & Cuisine' group which was a joint initiative between the Patient Learning Centre and the Occupational Therapist in Iona Hub. This incorporated 3 practical activity sessions within the Hub therapeutic kitchen which was very positively received by the patients involved.

These themed learning groups were used to support and facilitate core skill achievements in 'Communication' and 'Working with Others'. The programmes comprised of learning that was open to all patients and each group was delivered over a 12 week period. This learning approach is now a regular option for patients, and patient feedback from the groups has been very positive.

Staff Development – A further 3 staff completed the SQA assessor qualification that is required to deliver national qualifications, and a further 1 staff member completed the tutor training required by Sports Leaders UK to deliver the Sports Leadership Qualification.

Review of Supervision Model

Discussions took place with our practice development colleagues regarding appropriate models of formal clinical supervision for the Support Staff group. It was agreed that the supervision would be facilitated by the Practice Education Facilitator and given the size of the staff group involved it was agreed that group supervision would be provided on a monthly basis. However staff were expected to attend 6 group supervision sessions throughout the year, therefore having the potential to attend bi-monthly group supervision. The group sessions commenced on 2nd November 2017. There have been 8 sessions planned (including June '18) with 6 sessions delivered to date. 2 sessions did not take place, x1 due to snow disruption, x1 no staff turned up due to miscommunication re date/time. During this period there were 64 attendances (n=22 individuals over the 6 sessions held)

Sickness

The staff sickness levels across the service have decreased over the past 12 months, averaging 4.94% in comparison to 7.13%.reported the previous year. Long term sickness has decreased 5.65% to 3.71% and short term sickness has continued to decrease slightly from 1.48% to 1.22%. The monitoring of staff sickness levels remains a focus for the Skye Centre Manager to continue to drive improvement in this area.

Social Events
The Skye Centre service continues to provide a series of planned social events throughout the year. These included the Celebration of Success and Achievements Ceremony acknowledging our patients engagement in the range of learning opportunities available to them. The Patient & Carer Christmas lunches and Christmas social and spiritual events were again delivered successfully and many positive responses were received from patients and carers regarding the enjoyment and quality of service they experienced. All of these events are accessed by patients and their carers. The success of these events can be attributed to the dedication and commitment of the Skye Centre and Involvement and Equality staff group. The annual Sportsman's Dinner was postponed at the beginning of the year due to the Financial Recovery Plan but has been rescheduled to take place on 20th June.

Carer Involvement
In support of National Carer's Week our Carer Event has become an annual event in the Skye Centre with our staff in the PLC, Vocational Activity Centres and Involvement and Equality colleagues hosting a range of planned activities which the patients and their carers can actively participate in followed by lunch in the Skye Atrium. The event in June 2017 was based around the national theme 'Building Carer Friendly Communities' and the staff ensured that a customary warm welcome was given to our patients and their carers.

Section 5 – Identified Issues and Potential Solutions

Recruitment
The service has experienced ongoing vacancies over the past 12 months and the recruitment process for these posts is ongoing.
The Gardens Activity Centre has been unsuccessful to date in recruiting to the Band 5 Senior Rehabilitation Instructor despite several targeted adverts being placed. Staffing contingencies have been put in place to minimise centre closures and the service has utilised the skills and knowledge within the existing staff group to maintain a level of horticulture activities for our patients. The Skye Centre Leadership Group have identified the need to review this service area and this will commence in June 2018 carried out by the Senior Charge Nurse with input from the Lead AHP. The outcome of this review will inform the range of activities that are on offer and also determine whether the full range of learning programmes can continue to be delivered.

Redesign of Woodwork Centre
In April 2017 the SMT approved the option to close the Woodwork and redesign this area into a generic therapeutic space in which a range of planned individual or group activities can be facilitated by a range of professionals i.e. Skye Centre, Occupational Therapy, Arts Therapy, Involvement & Equality. There are a number of existing groups, time limited in nature that could also utilise this space.

There have been delays in modifying and clearing the room however there has been good progress made within the past month. There are plans are in place to involve our patients in this work and a group have been identified to repaint the floor within this space which will take place before the end of June.

Section 6 - Future Areas of Work and Potential Service Development

Redesign of Woodwork Centre
In order to progress with the proposed change in practice, further work and discussion requires to take place with the H&S Committee and SMT to take forward the recommendations for the Skills Mix Review which will support an integrated multi-disciplinary model to facilitate groups. The Skye Centre Manager has prepared an SBAR for discussion at both forums. This is an area of priority to be progressed.

Patient Active Day Project
Further evaluation of the Active Day Model is currently taking place in relation to the Iona Project taking into consideration feedback from patients and the wider clinical team members regarding this patient group engagement whilst at the Skye Centre and the potential impact on those patients remaining on ward.

Activity Scheduling
A robust business case for the purchase of the electronic scheduling system CELCAT was completed and approved by the IT Sub Group and SMT in April 2017 and added to the eHealth project list. Unfortunately no funding has been allocated for this.

Following discussions held at by the Electronic CTM /Rio Group it was agreed to include information around patients' timetables therefore providing clinical teams with accurate information related to the activities across the hospital that each patient has participated in. This information would relate to both planned activity and activity attended on a drop in basis or ad hoc basis. By recording this information on RIO it will enable the organisation to collate more individualised data on patients' activities from across the professions and not solely the Skye Centre.

A small sub group has been established with representation from the Skye Centre, AHP and Involvement and Equality to identify the range of activities to be included and agree the most appropriate way for this to be presented. Our e-health department have also developed a draft form which will be completed on Rio. Work continues on the timetable and it is anticipated that this will be available within the coming months. This would enable the Skye Centre along with the other services to plan patient activity in a more efficient manner.

Supporting Health Choices
Skye Centre engagement with the Supporting Health Choices group is ongoing and the Shop staff and Sports & Fitness staff continue to demonstrate their support and deliver the agreed priorities for this plan of work. Both areas are actively involved in supporting the development of the Health and Well Being plans for our patients.

ONE LAN
A Skye Centre Senior Charge Nurse was requested to establish a subgroup as part of the Patient Active Day Project to introduce the ONELAN TV screens across the Skye Centre and the Hubs. The purpose of these screens is to keep patients informed and share information. Training was provided for the members of the subgroup regarding the use of the system. When the system is rolled out to the hubs it is anticipated that OTs will play a significant role, and use the system to advertise hub based activity. The staff who have had the training are able to provide this level of training for other staff.

In terms of content, 3 sections have been agreed:

- A large poster type box that will refresh and display info regarding upcoming events, health promotion and weekend activities. This info will be changed as required, weekly/fortnightly etc.
- A 'daily news' box that will scroll and display info re drop-in activities and ad hoc Atrium activities (focus away from closures with emphasis on what is available)
- A fixed text box at the bottom re menu changes.

'Accessible Information' training will be provided to the staff who will be using the system and adapted User Guides to make them TSH user friendly have been developed. Templates will be drawn up to ensure everyone uses the agreed format, agreed logos etc.

It is anticipated that the 'go live' will take place in the Skye Centre by the end of June 2018. The IES team will assist with gaining immediate patient feedback on the system re text/info/appropriateness/usefulness/accessibility etc. and the sub group will meet again to discuss and implement changes suggested by the patients- and it is hoped this will be a quick/responsive process.

Once the Skye Centre system is in place and patient feedback has been sought then the next step is to implement in Arran Hub. This will test out other aspects of the system, such as displaying screens with info specific for Arran or Skye Centre.

Outcome Measures

Further to discussions held at the Mental Health Practice Steering Group and the ongoing work related to Outcome Measures, Jamie Pitcairn, Research Manager, has agreed to support the Skye Centre Leadership team to further define the existing measures to reflect the work carried out and support the service's governance arrangements.

Evening Social Activities

In response to feedback from our patient group via the What Matters To You events and the PPG a monthly programme of weekday evening social activities will be piloted during the summer months, starting in June 2018. The Atrium staff have demonstrated initiative and provided solutions as to how these groups could be facilitated and have volunteered to work an alternative shift pattern to accommodate extended hours in order to facilitate the activities. The first event will be focussed around the theme of the World Cup and patients will be provided with their evening meal in the Skye Centre rather than on the ward. A total of 39 patients have requested to attend.

Recruitment

The recruitment process is at various stages in order to fill our current vacancies and discussions are ongoing with the Clinical Operations Manager regarding the current workforce numbers and skill mix to ensure succession planning is built into future service delivery and that the current service meets the needs of our patients.

Efficiency Savings Targets

The importance of ensuring that agreed efficiency targets are achieved is also recognised. The Skye Centre service has achieved and in fact exceeded the agreed savings target last year on a recurring and non-recurring basis, with £50k identified as recurring savings for the financial period 2017/18. For the financial period 2018/19 the agreed savings target is £187k. The necessary steps have been identified to meet the agreed savings target.

Section 7 – Financial Implications

There are no major financial implications with regards to delivering the service developments described above, however it will require new, innovative and integrated models of practice and staffing to be agreed and implemented. The desired change ensuring that the most appropriate range of activities are delivered safely and effectively.

Section 8 – Next Review Date

The next annual report will be provided to the Board in June 2019.

Skye Centre Complaints	1 June 2017 - 31 May 2018
Stage 1 Complaint	6
Stage 2 Complaint	3
Escalated to Stage 2	2
Total	**11**

Appendix 1

First received	Type	Description (Policies)	Sub-subject (primary)	Outcome	Outcome
01/11/2017	Stage 1	Patient complained about staff shortages affecting his ability to attend placements at the **Skye Centre** preventing him get escorted walks.	Shortage of Staff	SCN reports some progress with AHP colleagues indicating they may be able to assist with escorting patient to placements. SCN will discuss staffing implication/operational impact with Lead Nurse. Patient satisfied with this and withdrew complaint.	Withdrawn
01/12/2017	Stage 1	Patient wished to express his frustration regarding his **placement** being closed again due to lack of	Patient Activity & Recreational	Passed on to Skye Centre Manager to note and for action as appropriate.	Fully Upheld
01/12/2017	Stage 1	Patient complained about access only being able to access the **hospital shop** once per week.	Shop access/products	13.12.17 - SCN met with and discussed the issue with the patient and advised that the request to access the shop more frequently would be discussed at the Supporting Healthy Choices Group. However, on futher discussion with the team it was decided that this issue could be progressed quicker via the Skye Leadership Group, as the team identified areas that required further exploration. The aim is to discuss this at the Leadership meeting in January 2018.	Not Upheld
12/01/2018	Stage 1	Patient complained that he could not access the Skye Centre **drop in** service.	Patient Activity & Recreational Service	Delay in response due to patient being in seclusion. 25.01.18 Verbal Update provided by Skye Centre NTL met with patient on ward to discuss and resolved successfully. Patient had attended Skye Centre on 12 January AM and PM but asked to return to ward as he was unable to cope with the session. On returning to the ward the patient then demand a drop in session.	Not Upheld
13/02/2018	Stage 1	Patient complained that his **placement** was closed again today preventing him from completing his project.	Shortage of Staff	15.02.18 - Skye Centre Manager met with patient and apologise for the closure and explained the short term savings plan in place for the next few months which may affect services.	Fully Upheld
20/03/2018	Stage 1	Patient complained via PAS about the **infrequency** of haircuts.	Shortage of Staff	Patent accessed service yesterday and had haircut. Current savings plan which mean SC staff are working on wards is having an impacting on resources in Skye Centre at this time. SCN discussed with ward who liaised with patient. PAS to follow up with patient next week.	Fully Upheld
21/08/2017	Stage 2	Patient complained about the attitude of the **GP** during consultation.	Staff Conduct	GP apologised for any distress caused and offered an unconditional apology for any misunderstanding. Patient offered referral to internal physiotherapist and external pain management service. GP also agreed to discuss the complaint with colleagues, recommend that drugs like the one in this complaint are discussed at the medicines committee, will write and disseminate a significant analysis on the complaint to colleagues and discuss at annual appraisal.	Not Upheld
24/11/2017	Stage 2	Difficulties in staff availably to escort patient to **placements** in Skye Centre.	Shortage of Staff	Stage 1 01.12.17 - NTL met with patient to discuss. During meeting patient accepted that the delay in getting to the Skye Centre was due to special circumstances, inclement weather and grounds access cancelled and escorts being limited to 15 patients. SCN to liaise with Skye Centre staff in an effort to make sure escorts are carried out punctually, avoiding any lost placement time which seem to occur on Tuesday which coincides with Lewis's patients day and some ambiguity to who is responsible for escorting. Patient accepted apologies for delays and happy that his complaint has been listened to and believes these actions will be suffice to resolve his complaint. Stage 2 SCN met with patient 11.03.18. Patient advised that since submitting complaint his circumstances have changed; he now has grounds access so no longer relies on staff escorts and therefore wished to withdraw his complaint.	Withdrawn
27/11/2017	Stage 2	Patient complained about the time it has took for the hospital **GP** to diagnose his condition.	Staff Conduct	Patient reviewed regularly during the period prior to hospital admission. There was no evidence to suggest any concern relating to any of these contacts.	Not Upheld
04/12/2017	Stage 2	Patient complained about the lack of choice and the availability of fruit from **hospital shop**.	Purchasing	04.12.17 - Acknowledged in person with the patient. The hospital shop agreed to stock fruit with skins prior to the cessation of tesco. Choice was widened to include a variety of berries and fruit is now source from an external supplier, in addition to the kitchens. Fruit is also now delivered throughout the week creating more availably. Fruit can also be purchased by patients whilst attending the Skye Centre out with their shop day.	Partially Upheld
07/12/2017	Stage 2	Patient complained about the length of time it has taken to repair the coffee machine in the Skye Centre **Atrium**.	Patient Activity & Recreational Service	S2 In order to meet the requirements of the Skye Centre Atrium a replacement coffee would need to be modified to ensure that it functions without the use of cash, in order to allow patients to use it. Ms Garrity has discussed this with Kenny Andress, Head of Estates, who has advised that, at this time, we are unable to source a replacement machine that meets these needs. S1 SCN contacted the ward to inform patient that discussions about a new coffee machine are ongoing and progress was anticipated by end Jan/beginning Feb 2018.	Fully Upheld

Appendix 2a

Case Study - James

In order to uphold confidentiality and protect the patient's right to anonymity, the pseudonym 'James' will be used when referring to the patient concerned.

James is a 39 year old Caucasian gentleman who was transferred to The State Hospital from the prison service for an assessment period. He has a history of Conduct Disorder, substance misuse from a young age and has traits of Dissocial Personality Disorder. In recent times, he had been abusing new psychoactive substances and is believed to have experienced some exacerbation of paranoid thinking and possible false perceptions as a result.
The Sports & Fitness Centre contacted the ward regarding James participating in the Sports and Fitness Induction. The staff contacted the ward within 48 hours to ascertain his suitability to attend and he undertook his Hub Gym Induction within 5 days of arriving at the Hospital. Due to CTM concerns regarding his poor mental health and challenges settling into the ward routine, the Sports staff were advised it may take a more time before James would be able to tolerate time off ward to attend his Sports Assessment at the Skye Centre. The Sports staff contacted the ward fortnightly for updates on James' progress and the time came when he was able to complete his Sports Assessment, 7 weeks after admission. He expressed a strong interest in physical activity, particularly contact sports such as football and volley ball.
James was also identified by the Skye Centre Induction team 2 weeks after he was admitted. The Skye Centre nurse sent the initial e-mail to James' key worker regarding his suitability for Induction and this was raised at the next CTM. James was approved by the CTM as suitable to participate in the Skye Centre Induction 4 weeks after admission and commenced the group sessions 11 weeks after admission
Initially, joint working was a challenge as there was no input from the OT at the start of the Induction process due to the full-time Hub OT having left the hospital to take up another post and the other Hub OT working part-time. Therefore, the Induction team got in contact with the OT from Arran Hub and asked them if they were able to facilitate this. The Arran OT was already involved in this specific Induction course for another patient and therefore agreed to be a part of the process for this particular patient. The Arran OT attended a few of the Induction sessions to assess both patients progress and from the initial meeting, identified treatment objectives for James. The Arran OT noted through their observations that James had the tendency to dominate conversation and this may have been driven by his mental illness. She advised that if this behaviour continued, there could be a need for OT assessment and intervention. The Skye Centre Nurse and OT agreed to review this objective every 2 weeks and increase the frequency of this if circumstances changed.
The Induction programme ran for a total of 4 weeks, every Monday and Wednesday afternoon with the exception of one Monday afternoon where the Skye Centre was closed due to it being a public holiday. OT were involved in the Induction process from start to finish and attended a few of the sessions to review James' progress. James attended every allocated session without issue and maintained his enthusiasm and motivation throughout the process. Apart from initially experiencing normal nerves, James appeared to settle quickly into the environment and participated well in group discussion and activities with both staff and peers alike. As he progressed through the Induction, his initial nerves and reservations began to subside and he presented as less anxious and his tendency to dominate conversation had reduced significantly.
In conjunction with the Skye Centre Induction sessions James attended the Sports Admission sessions twice weekly where he was given the opportunity to participate in various activities and become more familiar with the environment off ward. These sessions commenced immediately after the completion of the Sports Assessment.

Cont.

James quickly developed an interest in a number of the Activity Centre's and now attends the Skye Centre for 6 planned activity sessions. Ranging from Sports, PLC and Crafts. James attends consistently and also participates in drop in sessions. In addition he attends weekend social activities, PPG and Multifaith service on a weekly basis. James himself reports that he enjoys being kept busy and having more of a structure to his day/week.
He is enthusiastic and motivated, in particular enjoys Sports and is aware of the positive effect physical activity has on both his physical and mental health.

Louisa Lynch, Band 5 Nurse – Skye Centre Atrium
Hazel McGinty , Senior Rehab Instructor – Skye Centre Atrium
Nicole Jordan, Charge Nurse – Sports & Fitness

Case Study - Joe

In order to uphold confidentiality and protect the patient's right to anonymity, the pseudonym 'Joe' will be used when referring to the patient concerned.

Joe is a 20 year old Caucasian gentleman, who was referred to the State Hospital after experiencing an episode of psychosis. Joe is a complex individual to discuss as he was registered blind at the age of 15 and has a historical diagnosis of mild learning disability with significant emotional and behavioural difficulties, including anger issues and possible ADHD. There is also a significant history of alcohol misuse/dependence dating back to his early teenage years. It has proved challenging to engage Joe in planned activities due to the nature and complexity of his needs; therefore, the Induction team created a tailored programme to suit which was centred around his specific needs. It was acknowledged that he required a higher level of input/support from staff and the view was taken that he would struggle to cope within the wider Induction group setting.

Prior to commencing his Induction, the Skye Centre nurse contacted Joe's key worker on numerous occasions from admission to discuss his suitability to participate in the Induction process. Initially, Joe was not approved to access the Skye Centre due to his poor mental state and presenting challenging behaviours. This meant that he did not receive approval from his clinical team until his clinical presentation improved, which was 24 weeks after he was admitted. Joe was subsequently commenced a tailored induction 2 weeks after receiving approval from the CTM.

With regards to the Sport & Fitness Induction the ward were contacted 48 hours after admission however Joe was not considered to be mentally fit to participate in a Hub Gym Induction. This however did take place 5 weeks after his admission. Subsequently Joe refused to engage in the Sports assessment or attend tailored admission sessions within the Sports & Fitness Centre. The Charge Nurse in Sports regularly discusses Joe's progress with the ward staff and the patient himself but he still refuses to participate in any physical activity stating that he is too anxious. The Sports staff agreed to explore other suitable activities that may encourage Joe to engage.

The Skye Centre nurse then contacted the Hub OT following the completion of the MOHOST assessment to discuss joint treatment objectives. Examples of the treatment objectives identified were: encouraging interaction with peers as he had a tendency to self-isolate, encouraging sensory exploration and introducing new hobbies and interests, as the patient had not formed any interests or felt a sense of enjoyment from activity due to his difficult and challenging background. The Hub OT and Skye Centre nurse agreed to review these objectives on a weekly basis, increasing the frequency if required to reflect changing circumstances.

The tailored programme ran for a total of 4 weeks (every Monday and Wednesday afternoon) and involved an introduction to the different Activity Centres and staff across the service. OT was also involved in this process and made an effort to attend almost every session. These sessions took into account Joe's disability and ensured that the activities offered were appropriate and suitable for him. As Joe progressed through his Induction he began to show a

keen interest in the Gardens department and enjoyed the animal therapy aspect of this. This was the first time Joe had ever had the opportunity to pet small animals and he responded very well to this, displaying enjoyment and demonstrating caution when handling the animals. Joe was also noted to be socialising more with peers in this department and appeared to be responding well to help and assistance from another patient. This patient had previously worked as a 'buddy', assisting less able patients and offering peer support. The Induction team identified this interest of Joe's early on and were of the view that on completion of his Induction he would benefit from being assigned a 'buddy'.

Following completion of his Induction, Joe identified future placements he was interested in: Gardens and Sports. The Skye Centre nurse forwarded this list of placements on to his key worker for referral and discussed a flexible placement plan in order to engage but not overwhelm the patient. Jo was also provided the opportunity to engage with the Atrium's 'Hard to Reach' activity sessions, which assertively outreaches more complex and difficult to engage patients with the aim to improve their quality of life. Overall, this Induction was considered a success as the patient now regularly attends the Skye Centre for 3 sessions a week and is more proactive in requesting drop-in's at the Atrium. This patient has also been referred to the 'Buddy Session' within the Gardens and will be allocated a placement within this department.

Louisa Lynch, Band 5 Nurse – Skye Centre Atrium
Hazel McGinty , Senior Rehab Instructor – Skye Centre Atrium
Nicole Jordan, Charge Nurse – Sports & Fitness

Board paper 18/32

NHS SCOTLAND

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	28 June 2018
Agenda Reference:	Item No: 10
Sponsoring Director:	Medical Director
Author(s):	Chair SHCIG
Title of Report:	Supporting Healthy Choices

1 SITUATION

Patients in The State Hospital suffer from weight gain and associated physical/mental health problems. Their BMI is 20% higher than the normal Scottish population.

2 BACKGROUND

Supporting Healthy Choices Implementation Group (SHCIG) was formed in September 2016, and has continued to meet on a monthly basis since then. The group are tasked with implementing the 15 point prevention and reduction plan approved by the Board in June 2016.

3 ASSESSMENT

See detailed work plan below.

4 RECOMMENDATIONS

The Board is asked to **note** this update report.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	SHCIG supports the implementation of the Boards' 2016 recommendations for patient health and wellbeing.
Workforce Implications	See work plan for specific details
Financial Implications	See work plan for specific details
Route To Board Which groups were involved in contributing to the paper and recommendations.	Supporting Healthy Choices Implementation Group, Clinical Governance Committee
Risk Assessment (Outline any significant risks and associated mitigation)	Not required – Group update only
Assessment of Impact on Stakeholder Experience	Not required – Group update only
Equality Impact Assessment	Not required – Group update only

PREVENTION

Recommendation		Evidence/ Rationale	Progress	Lead	Timescale
1	The Hospital should clearly communicate and monitor the standard that newly admitted patients can access off ward services and grounds when individually assessed as appropriate by the Clinical Team and not purely as a consequence of reaching a first case conference.	• Better informed patients • Evidence of weight gain on admission • Clarity for all CTMs • Earlier opportunities for activity for admitted patients	Jamie Pitcairn presented the new admission guidelines document to SMT in May 2018. Some modifications are required. Currently awaiting final approved document.	**Jamie Pitcairn**	**January 2018 (**delayed**)**
2	On admission every patient should be provided with a Patient Information Pack, which will include information on nutrition, physical wellbeing and the obesity risk factors at the Hospital	• Better informed patients • Evidence of weight gain on admission	Interim fact sheet was shared with the SHCIG for approval and completed in Spring 2017. See point 4 for further progress on updates to the carer welcome pack.	**Sandie Dickson / Frances Waddell**	**Completed**
3	A learning module / pack on nutrition, exercise and wellbeing should be developed	• Better informed patients • Improve individual decision making	A physical activity booklet has been produced. Tracy Tait is now in the process of liaising with Jackie McQueen and nursing staff to pilot the booklet with a small, selected	**Tracy Tait**	**March 2018** (Delayed)

	and made available to all patients.		cohort of patients. Feedback will follow		
4	A learning module / pack should be developed and made available to all carers and patient visitors. See update – information sheet to be included within new Carer Welcome Pack instead of the introduction of a learning module.	• Better informed carers / visitors • Improve individual decision making • Support patients decision making	New information sheet has been developed and is now included within each Carer Welcome Pack.	**Sandie Dickson**	**Completed**
5a	Every patient should have an individual analysis of intake and output to inform their healthy lifestyle plan, shopping plans and meal selections.	• Person centred • Evidence and rationale established for tailored individual plans	**See point 5b**	**Frances Waddell**	**July 2018**

5b	On admission following nutritional screening, patients will be allocated a generic Health and wellbeing plan based on their current BMI and Nutritional Screening Tool risk score. This plan will be individualized where necessary. Prior to the admission CPA, Occupational Therapists, Key Workers and Dietetic staff (and other relevant members of the MDT where necessary) will meet with the patient (if able) and will develop the initial 'Health and Wellbeing Plan'. The plan will cover dietary intake, activity, psychological wellbeing and cessation of smoking (where necessary). These plans will be reviewed at least 6 months.	• Evidence of weight gain on admission • CTM ownership and responsibility	8 Health and Wellbeing Plans were approved by the Clinical Governance Group in April 2018. Frances Waddell and Catherine Totten will update the PHSG about implementation of these plans and clarify resourcing issues	**Frances Waddell** **Catherine Totten** (to support the dietary service for implement ation)	**July 2018** **(**to start implementing the plans**)** **June 2018**

6	A Physical Health Steering Group sub group should undertake a scoping exercise to identify further methods (both group and 1:1) to support patients to engage in healthy lifestyles which include opportunities for a co-production approach, including outdoor activities / pursuits.	• Benefits of co-production • Benefits of peer support • Benefits of role modelling • Wider variety / choice of methods	An electronic CTM pilot commenced in Lewis on 16/04/2018. The new format will prompt discussion of physical activity and LDP targets**. Dr Alcock** will advise hospital wide implementation across the hospital	**Alison Buchanan**	**Pilot Completed in Lewis (**next step to start in other hubs**)**
			Natasha Winters (OT) will look into co-production opportunities and provide feedback at the next meeting.	**Natasha Winters**	**June 2018**

REDUCTION					
Recommendation		**Evidence/ Rationale**	**Progress**	**Lead**	**Timescale**
7	The Physical Health Steering Group should set up a sub-group tasked with developing the existing 'Slim and Trim' Group and 'Healthy Living' Group for implementation within the hub / ward environment.	• Benefits of co-production • Benefits of peer support • Benefits of role modelling • Wider variety / choice of methods • More local provision • Encourages staff Health Improvement	Healthy eating, healthy living, and slim and trim are up and running. Frequency of these meetings is dependent on the number of referrals and staffing resources.	**Dr L Kennedy**	**Completed**

8a	A Hospital Shop Project Group should be established to review the service model, including stock availability; healthier options, non food options, pricing, staffing and access.	• Patients large disposable income • Non food provision • Healthier provision • Patients as co-workers • Introduction of shopping plans	In November 2016, the shop was remodeled as per the Healthy Retail Standards (20% unhealthy / 80% healthy compliance).	**J. Garrity**	**Completed**
			Staff report that the majority of shop income is generated from the non-compliant (20%) confectionary items available. There is currently no individualized limit to purchasing confectionary and this 20% of the stock is continually replenished during shop visits. Produce a list of items within the shop so that individuals who cannot attend the shop are able to see things. Use photographs if needed. Alison Buchanan can provide admin support.	**J. Garrity**	**Ongoing**
			Healthy Retail Standard changes to the shop has reduced a patient's choice of unhealthy items by 80% but the change has had little or no impact on individual purchasing habits. Shop staff continue to feel that they are unable to challenge amounts purchased by individuals given Health and Wellbeing Plans are not in place.		
			Tom Hair is in talks with businesses to provide an Electronic Point of Sale (EPOS) within the Hospital Shop. Meetings have taken place to purchase an Electronic Point of Sale (EPOS) system for	**Tom Hair**	**November 2017 (**delayed**)**

			the hospital shop. Such a system would allow the shop to track patients' purchases. Initially this project was delayed due to IT resourcing constraints and the hospital budget. GDPR compliance questions posed to the providing company is the current reason for delay. Feedback will follow.		
8b	The practice of patients ordering food items from supermarkets should stop and in conjunction review pricing and stock availability in the Hospital shop.	• Organisational burden → Security Dept, Finance Dept, Procurement Dept, Key Workers • Replicate provision / costs in Hospital shop where appropriate and doable. • Currently key source of additional foodstuffs entering the Hospital • Security considerations and risks • Current system of restrictions not working well	External food procurement ceased on 31/10/2017.		**Completed**
9	An electronic or paper system to support individual 'shopping plans' should be developed.	• Person centred approach • Patient responsibility encouraged • CTM responsibility encouraged • Efficient working	See 5a and 5b	**Frances Waddell**	**July 2018**
10	A short life project group to explore supervised patient access to the internet for purchasing non food items should be	• Better use of patients large disposable incomes. • Patients spend less on food • Patients' competence in e-Health improved. • Life skills development as part of	It has been difficult to demonstrate consistency of approach across the Hospital as a result of mainstreaming the pilot project which aimed to enable daily ordering. This has been due to resourcing challenges in relation to prioritising clinical care.	**Stuart Lammie / Jackie McQueen / Thomas Best**	**November 2017** (Delayed)

	set up.	rehabilitation	The technological solution therefore remains the most effective way of supporting wider access to an enhanced shopping experience. e-Health are now fully staffed. Thomas Best, Stuart Lammie & Jackie McQueen have been invited to the June Supporting Healthy Choices meeting to discuss how best to move forward with the use of technology.		
11	Carers should continue to bring food items based on individual healthy lifestyle plans to which carers have contributed, within the confines of a reviewed restrictions list, and taking into account any agreed restrictions on volume and calorific content.	• Carers very keen to support patients healthier lifestyles • Carers still retain ability to provide food gifts / ~~comfort~~ • Person centred yet within limits	The Visitors / Carers subgroup will liaise with carers once the Healthy Wellbeing Plans are finalised and in place. Following introduction of the information sheet for carers, monitoring of the quantities of food and fluid items being brought into the Hospital should be considered to establish the significance of this issue. This was considered as impractical as this is not the role of Reception staff and nursing staff may not have time consistently to undertake this task, making the data unreliable. The updated food and fluids list (appendix 2) was brought to the May meeting for discussion. The group thought the new list was a big improvement on the current one however some concerns were raised around; visitors being able to continue to bring in significant quantities of unhealthy food / fluids for patients. There are some tensions around the role of Reception staff in respect of compliance to restricted / prohibited items and the role of	**Sandie Dickson**	**October 2017** (delayed due to delay with development of Healthy Wellbeing Plans)

			ward staff to analyse what food / fluid items are brought to the Hospital. This issue requires discussion with the SHCIG and Clinical Operations Manager in the first instance.		
			Food/fluid items are being sent via post/courier. The current understanding is that volumes are low; however, there may be an increase in this practice, as a result of the cessation of external supermarket procurement. This issue requires careful consideration as there are potential legal implications in respect of restricting access to patients' mail. SHCIG to make recommendations to Medical Director who will seek advice from CLO prior to SMT SBAR.	**Dr Khan**	July 2018
12	A small amount of 'ward-sized' exercise and activity equipment should be purchased for each ward that allows OTs, Health Champions and nursing staff to provide / support ward based exercise groups. This should be used to supplement the facilities of the Hub gyms, not replace them	• Patient access to exercise improved • CTM ownership and encouragement • Encourages staff Health Improvement and role modelling	SBAR will be re-submitted to SMT in June 2018. Originally submitted in September 2017		Delayed due to financial constraints

	and piloted in 2 wards as a 'small test of change'.				
13	The current outdoor gyms should be relocated to be more visible, accessible and integrated than they are currently.	• Patient access • Profile and prominence	Pieces of exercise equipments have been relocated to the central grounds.		**Completed**
14	The Catering Service should review the current service provision with regards to assisting with weight reduction programmes; in particular it should consider: (i) Calorific value notification for each menu product (ii) The times that meals are provided for patients.	• More informed choices by patients • Reduce time between last and first meal and snacking • Calorie intake modified	New menu will be introduced in May 2018. PPG and Catering have been involved in the process. Additional meetings regarding national nutritional database are due to be held and Frances Waddell will provide feedback when available.	**Frances Waddell**	**Completed** **Ongoing**
15	Patients should continue to have access to a single carryout meal once per month, in line with the new guidance from the Infection Control Committee.	• Normalisation • Person-centred • Minimise cross-infection risk	This is governed by the existing takeaway guidelines.		**Completed**

APPENDIX 1

Journal Club Presentation 29/01/2018:

Promoting Healthy Lifestyle and Tackling Obesity in Secure Settings – Our Research and Clinical Implications by Dr Rajesh Moholkar, Consultant Forensic Psychiatrist, Physical Health Lead, Birmingham and Solihull Mental Health Foundation NHS Trust

Discussions / Suggestions from that meeting

The following themes were discussed (and who raised it) during Journal Club on . These WILL be given further consideration by the Supporting Healthy Choices Group meetings during 2018 and a further Journal Club presentation will occur in the summer of 2018:

1. Limiting take away orders further to allow patients to choose healthier options – Nicola Watt
2. Limiting the consumption of multiple bread rolls at lunch/dinner time – Lindsay Thomson
3. Explore set snack times promoting healthier choices at night – Rebecca
4. Explore existing processes (ie: takeaways) and how they are used in practice on the wards – Karen Burnett / Clinical Effectiveness audits
5. Explore tracking of spending in hospital shop per patient in relation to benefits – Tom Hair/Lindsay Thomson
6. Await outcome of Weight Management plan audit – Dr Amy Preston
7. Explore duty of care and how the clinical team fulfils this – Dr Khan
8. Explore possibility of more meaningful day time activities including patient jobs – Julie McGee
9. Explore ward based activities in the evening to prevent patients from becoming bored and comfort eating – Sarah Innes
10. Explore how the hospital can prevent sports placement closures - Nicola Watt

APPENDIX 2
THE STATE HOSPITAL LIST OF APPROVED GIFTS OF FOOD AND FLUID ITEMS FROM VISITORS

We recognise that due to a combination of some of the prescribed medication, a sedentary lifestyle, access to unhealthy snacks and reduced motivation, particularly in the initial phase of the recovery journey, patients are more likely to gain weight whilst in the Hospital.

In addition to enjoying nutritionally balanced meals cooked on site, our patients currently supplement the recommended daily average calorific intake via the Hospital shop and gifts of food and fluids from visitors.

Having a healthy lifestyle helps patients to feel good – physically, mentally and emotionally. We work closely with patients, supporting them to balance how much they eat with how much they exercise. We rely on visitors working with us to support patients to make changes to their lifestyle, particularly around access to snacks.

A selection from the following list may be brought into the Hospital per visit. The number of items are determined per visit rather than per visitor.

- Bags / nets / trays / punnets of fruit with peeling skins (e.g. apples, oranges, grapes, satsumas / clementines, bananas, pears).
- One punnet / tray / pack of soft fruit (e.g. blueberries / strawberries / plums / cherries).
- One individual bag of dried fruit or nuts.
- Three bottles (maximum 1.5 litre each) no added sugar diluting drinks, no added sugar still / carbonated flavoured / plain water and sugar free fizzy drinks (e.g. squashes or cordials, sugar free fizzy drinks).
- Six small UHT (long life) cartons of fruit juice / smoothie.
- Teabags, coffee, and /or other hot drinks (e.g. malt, hot chocolate).
- Four individual pots of UHT (long life) desserts (e.g. custard, yoghurts, rice, fruit).
- One plastic container of preserves e.g. jams, spreads (chocolate, peanut, honey) – **which do not require refrigeration after opening.**
- Four standard chocolate bars or packets of sweets (e.g. mints, gums).
- One packet of biscuits or crackers.
- One small pack of individual cakes / cereal bars.
- Six individual standard bags of crisps / savoury snacks (e.g. Bombay Mix).

- Breakfast cereal.

In addition:
- A manufacturer sealed birthday cake (no fresh cream) may be brought in the 2 week period before / after a patient's birthday.
- One Christmas /seasonal item (e.g. selection box, chocolate Santa, box of biscuits (in a plastic container) etc) during the month of December.
- One standard size chocolate egg in the 2 week period before or after Easter.

Visitors' Personal Requirements

In addition to the items being brought in for patients, visitors may bring in one item of fluids (e.g. sugar free fizzy drink) up to 500ml for personal consumption during the visit and /or one item of food e.g. standard bag of crisps, standard bar of chocolate, packet of sweets/piece of fruit or prepared packet of fruit. These must be bagged separately and identified as being for personal consumption during the visit.

Food and Fluids Which Cannot Be Brought Into the Hospital

- Alcohol or any products containing alcohol (i.e. chocolates, cakes, pies, some festive products).
- Any products in a tin or glass container including coffee.
- Chewing / bubble gum.
- Any products requiring refrigeration / freezing at point of purchase or after opening e.g. fresh fruit juice, smoothies, some pre-prepared fruits or vegetables, milk shakes, some sauces / jams / yoghurts, smoked sausage, olives, items containing fresh or artificial cream, pre-wrapped sandwiches, cheese.
- Any item without a manufacturers' seal (e.g. supermarket bakery items, cakes in bakers' box, home baking etc)
- Any item containing grapefruit or grapefruit juice.
- Raw meat, fish, poultry or eggs or related products (e.g. gravy, meat pies, salami sticks, beef jerky, scotch eggs, stock cubes / sachets etc)
- Supplements such as protein powders / bars, energy drinks, multivitamin and mineral supplements or other similar items (unless otherwise agreed).

On some occasions a decision may require to be made by the Clinical Team in respect of food and fluids which may affect individual patient care and treatment plans in line with their Nutritional Assessment and associated Health & Wellbeing Plan.

The Hospital appreciates that some people may visit infrequently and, as a result, may wish to bring larger quantities of non-perishable food and fluid items. If you visit less than 4 times per year, please contact the ward prior to your visit to discuss options. Staff will consider your request in relation to the patient's Health & Wellbeing Plan, in addition to potential constraints around storage.

NHS SCOTLAND

THE STATE HOSPITALS BOARD FOR SCOTLAND *CG(M)02*

Minutes of the Clinical Governance Committee Meeting held on Thursday 10 May 2018 at 9.45am in the boardroom, The State Hospital, Carstairs.

CHAIR:

Non Executive Director	Nicholas Johnston

PRESENT:

Non Executive Director	Elizabeth Carmichael
Non Executive Director	Maire Whitehead

IN ATTENDANCE:

Senior Nurse – Infection Control	Karen Burnett [Minute 6]
Chief Executive	Jim Crichton
Chairperson	Terry Currie
Chair of Medical Advisory Committee	Khuram Khan
Finance & Performance Management Director	Robin McNaught
Head of Corporate Planning and Business Support	Monica Merson
Research & Development Manager	Jamie Pitcairn [Minute 7]
Director of Nursing and AHP	Mark Richards
Board Secretary	Margaret Smith
Clinical Effectiveness Team Leader	Sheila Smith
Medical Director	Lindsay Thomson

1 APOLOGIES AND INTRODUCTORY REMARKS

Mr Johnston welcomed everyone to the meeting. Apologies were noted from Gary Macpherson, Interim Head of Psychological Services.

NOTED

2 CONFLICTS OF INTEREST

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

NOTED

3 MINUTES OF THE PREVIOUS MEETING

The Minutes of the previous meeting held on 22 February 2018 were approved as an accurate record.

NOTED

4 PROGRESS ON ACTION NOTES

The Committee was content to note progress on the Minute Action Points from the last meeting.

- ***Duty of Candour***

A paper was submitted to update Members on progress made following implementation of the legislation on 1 April 2018.

Ms Merson highlighted the key points of the paper for Members, confirming that the first core group meeting had taken place, to review all documented incidents on Datix, the incident reporting system. There had been no Duty of Candour (DOC) incidents within The State Hospital (TSH) to date. This methodology of reviewing all incidents provided assurance at this time that no possible DOC incidents would be missed. It could be expected that the review process would change going forward.

There was continued focus on raising awareness throughout the organisation, and there had been a positive uptake of online learning sessions to date. All senior professional meetings had included DOC on the agenda in the past month, and would be part of practice sessions with nursing staff in June 2018.

Mrs Whitehead asked for further clarification on the action plan included with the paper, and it was confirmed that this was continually being progressed and updated, especially in relation to staff awareness and training. Ms Merson also provided a further update in relation to the baseline study carried out, and advised that the percentage of staff that felt supported in this area exceeded 75%. Any lessons that could be learnt from this analysis would be taken forward by the DOC group. Further progress on the action plan would be tracked over time.

Mr Johnston thanked Ms Merson and Professor Thomson and it was agreed that the Committee would received quarterly updates this year, given that this was the first year of introduction for DOC. This would be added to the workplan for the Committee.

Action: L Thomson/M Merson/ S Smith

NOTED

5 MATTERS ARISING

There were no further matters arising.

NOTED

6 INFECTION CONTROL – 12 MONTHLY REPORT

A paper was submitted to the Committee by the Senior Nurse for Infection Control (Karen Burnett) who was present to provide an overview for Members. She highlighted the work undertaken on the staff uniform policy, the launch of which in February completed the actions outstanding from the Health Inspectorate Scotland Report in 2016. She also highlighted the work progressed under the Scottish Infection Prevention Control Education Pathway (SIPCEP) in conjunction with National Education Services (NES).

Ms Burnett described the achievement made in the incorporation of Blood Borne Virus (BBV) screening in to the admission process from April 2017, with all patients consenting to this on admission. A further key achievement had been the development of the Acute Boarding Out Leave (ABOL) procedure with quality improvement measures put in place around the process and communication in place for day procedures and emergency admission to general hospital, as well as for overnight stays by TSH patients.

Ms Burdett advised the Committee that some of the key challenges in the coming year would be to improve on audit submission and ain to improve compliance rates. There was a commitment to improving staff uptake of the seasonal flu vaccine. It would be a priority to monitor compliance with after care needs identified during the ABOL procedure.

Mr Johnston thanked Ms Burnett for her summary of the report, and Mr Crichton congratulated her on the work progressed to date. He asked for clarification on staff uptake of the flu virus i.e. was this impacted by ward staff finding it difficult to access the service? Ms Burnett confirmed that the vaccine had been made available to ward staff on the hubs, but that this could be a time consuming process in terms of releasing staff from ward duties and each vaccination could take 30 minutes to carry out. However, this was effective in encouraging staff to get vaccinated. Mr Richards confirmed that a small seasonal variation in sickness absence could be evidenced, due to flu symptoms, and this was in the range of 1-2 %.

Mr Currie asked for clarification around audit results around cleaning services, noting that individual areas scored an Amber result due to staff sickness. Ms Burnett provided reassurance that when there were staff shortages in housekeeping, clinical areas would be prioritised meaning that non clinical areas had dropped into Amber. Mr Currie also asked about the completion of SIPCEP Modules, with some being audited at less than 50%. Ms Burdett confirmed that this would be reviewed this year with the aim of improving these compliance rates. It was also highlighted that 52 members of staff had not completed the BBV Training Module, and Mr Richards confirmed that this was an area for line managers to focus on with staff. Mr Johnston widened the discussion onto compliance rates for a number of modules and it was agreed that this was an area of concern for the Committee and should be tracked to monitor improvement.

Action – S Smith

In answer to a question from Mrs Whitehead, it was confirmed that it has not been possible to offer patients the opportunity to be vaccinated against hepatitis B due to a national shortage of the vaccine.

Mrs Whitehead raised the low compliance rate for hand hygiene in the Skye Centre and asked for reassurance as to how this will be actively prioritised this year. Ms Burnett confirmed that there would be review of where the hand sanitizer was located – the locale had security implications. Professor Thomson led discussion around compliance by medics noting that all psychiatrists entering the Skye Centre should use the hand sanitizer on each occasion. It may be the case that GPs and dentists were using the hand sanitizer on entering the Health Centre rather than at the Skye Centre entrance. The Committee asked Professor Thomson to raise general awareness among all medical staff on this issue.

Action – L Thomson

Mrs Carmichael welcomed the report which demonstrated a good record overall on infection control. As one of the key challenges highlighted was around compliance rates, she suggested that a detailed section of the report linking key challenges would be helpful. It was agreed that future reports would do so.

Action – K Burnett

The Committee welcomed the update in regard to the ABOL procedure, and asked for this to be included as an example of quality improvement in the good practice list.

Action – S Smith

The Committee noted the annual report for Infection Control.

<u>NOTED</u>

7 RESEARCH COMMITTEE – 12 MONTHLY REPORT

The research Committee Annual Report 2017/18 was submitted to the Committee on behalf of the Medical Director. Mr Pitcairn was in attendance to summarise the report for Members. He

highlighted the wide range of research activity within TSH and awards won, with the report providing a summary of work conducted within both the Research and Research Funding Committees.

Mr Currie asked for further detail on the reasons for delay in approving research by the Research Funding Committee. Mr McNaught clarified that changes had been made in the way the Research Funding Committee progressed its work with a remote system of approval being initiated should there be difficulty in meeting. The need to improve the administration was discussed as well as the continued need for both the Research Funding Committee and the Research Committee, in terms of overall governance. It was agreed that the Research Funding Committee should consider arranging three meetings throughout the year, and then assess the need for each meeting as it arose. It was noted that the system of remote approvals had brought about an improvement in approval timescales.

Action – J Pitcairn

In answer to a question from Mrs Whitehead regarding patient capacity adversely affecting response rate, Mr Pitcairn outlined some of the difficulties experienced in recent times. With a small cohort of patients, research opportunities could be limited. At the same time patients may feel that they are being asked to participate in too many requests, and it also may be that patients lack the capacity to participate. Data on patients' capacity to participate in research projects would be noted by the RMO to the Medical Advisory Committee. Dr Khan and Mr Pitcairn would liaise to obtain this data.

Action – K Khan/ J Pitcairn

Mrs Carmichael noted the wealth of information in the report about the research being undertaken, and suggested that it would assist the Committee to also learn about some of the impacts on clinical practice of the research and this could be subject to an annual progress report. Mr Crichton noted that a lot of research was translatable into practice whilst some may be part of a broader scope – there may be other mechanisms available to demonstrate the link between research and clinical effectiveness. Professor Thomson agreed and advised that at the end of a project report there would be detail in particular about whether the conclusion was translatable within TSH and across the Forensic Network. A good example of this was Healthy Choices. It should be recalled that not every project would be appropriate for implementation directly into TSH. At the same time, research opportunities could be important in attracting and motivating staff.

Mr Pitcairn also clarified that those conducting the research may not be the same staff responsible for implementing any agreed change to practice. Professor Thomson agreed to identify examples of research that had been put into practice, as well as a progress report on the impact of same.

Action – L Thomson

The Committee noted and approved the Research Committee Annual Report.

AGREED

8 ADULT AND CHILD PROTECTION – 12 MONTHLY REPORT

The Annual Report was submitted to the Committee on behalf of the Director of Nursing and AHPs.

Mr Richards summarised the report for Members, drawing their attention to the key priorities of keeping children safe as well as adult support and protection. He noted the work being progressed on training activities as well as future areas of work particularly taking learning from "near misses", the Corporate Parenting Plan, and measures introduced whilst the Named Person legislation was on hold.

In answer to a query from Mrs Carmichael in respect of linking incidents recording harm to complaints, Mr Richards confirmed that it was appropriate for these two systems to sit separately but that there was read across from one to the other. Mrs Carmichael also asked for reassurance in respect of staff being released to attend training sessions and Mr Richards confirmed that action had been taken to compile training sessions into half days making the training more accessible.

Mrs Whitehead asked a question around the appropriateness of TSH making contact with schools for any children visiting here. Professor Thomson confirmed that this would never be the case due to the breach in confidentiality and noted that should there be any concerns for a child, this duty of care to that child would be discharged through contact with social services.

The Committee were content to note the report, and to support the future areas of work identified.

NOTED

9 FITNESS TO PRACTICE – 12 MONTHLY REPORT

A report was submitted to the Committee for their information in respect of the process for monitoring professional registration status at The State Hospital thus providing assurance that all relevant staff held current professional registration as appropriate. The system was verified monthly for all areas of clinical practice.

The Committee noted the report and agreed that it should also be flagged to the Staff Governance Committee.

Action – M Smith

NOTED

10 PATIENT MOVEMENT – STATISTICAL REPORT

A report was submitted to the Committee on behalf of the Medical Director, which provided Members with an overview of the activity across admissions, discharges and transfer of patients as at 31 March 2018.

Professor Thomson provided an overview of the data for Members and the declining trend in bed occupancy was noted. Mr Crichton underlined that this was an important area in which the Board should have oversight for and to prepare contingencies for this. The Senior Management Team were sighted on this should the downward trend continue. He noted the development of further capacity within the Forensic Network for medium secure beds within the West of Scotland. There was also discussion around the female pathway within the Forensic Network and that a review was underway. It was noted that the Board expected to receive a further update once this had been completed.

The Committee were content to note this update.

NOTED

11 LEARNING FROM FEEDBACK

A report was submitted to the Committee, on behalf of the Medical Director, which provided an overview in respect of learning taken from complaints and feedback for the period 1 January to 31 March 2018.

Professor Thomson led Members through the details of the report, including the number of complaints and the main themes in these providing some detail on the background to these as well as whether the numbers of complaints that were considered to have been upheld. She highlighted

to the Committee that there were possible inconsistencies in the way complaints were being recorded and upheld or not, and confirmed that this had been identified as an area of development for the Risk Department.

Professor Thomson outlined the key issues raised through feedback for this quarter, including through the Patient Partnership Group (PPG) and the outcomes arising from the feedback reported.

The Committee considered how best to share and use the learning from this report and it was agreed that this could be taken forward through Hub Leadership Forums. This report and the report in the next item relating to incident reporting would be the subject of a staff bulletin. Mrs Carmichael agreed that this would fulfil the recommendation made through internal audit about sharing of reporting across the organisation.

Action – L Thomson/ S Smith

Mr Currie asked for clarification round what is recorded as the nature of the complaint and how to ensure accuracy and openness about the issues involved in any complaint raised. The Committee agreed that it was essential to be able to record the root cause of the complaint.

The Committee noted the content of the report, and that a report would be brought to the next meeting of the Committee for the first quarter of the current financial year.

NOTED

12 INCIDENT REPORTING AND PATIENT RESTRICTIONS

A report was submitted to the Committee, on behalf of the Medical Director, which provided an overview in respect of incidents and patient restrictions for the period 1 January to 31 March 2018.

Professor Thomson provided an overview of the report for Members and highlighted the increase in verbal incidents and placed this within the context of a decrease in the number of incidents overall. She also advised Members that the Risk department had experienced a period of under capacity, but that this would be resolved with the Head of Risk returning from a secondment at the end of this month, as well as successful recruitment to a new post of Risk Facilitator. Mr Johnston agreed that the impact of this was demonstrated in there having been no improvement in timescales for reporting of critical incident reviews.

Mr Richards noted that the number of seclusions per month did not necessarily demonstrate that the number of hours spent in seclusion by patients had increased, and it was agreed that this could be represented on a separate graph.

Mrs Carmichael queried the incident in which there was a positive result in oral testing, and Professor Thomson advised that she would source more information about this specific incident. In future reporting, the reason for the positive testing would be included.

Actions – L Thomson/ S Smith

NOTED

13 CIRS

A paper was submitted to the Committee providing an appropriately redacted copy of the full report into the critical incident review for CIR Reference: 17/02 around a series of assaults which took place during April 2017.

Professor Thomson provided a detailed summary of the report for the Committee providing the

background and circumstance to each incident. She led Members through the terms of reference of the review as well as the concluding recommendations. Mr Crichton confirmed that this report would be shared with Scottish Government.

The Committee expressed sympathy for the staff involved and wished each of them well. There was discussion around the detail of the incidents, and the Committee expressed reassurance with the terms of reference of the review and that the report demonstrated the thoroughness of the process and investigation undertaken. The Committee noted the changes made at local level at the time of the incidents and Professor Thomson confirmed the level of senior cover in place across a multi-disciplinary team comprising senior nursing staff, Clinical Observations Manager, the RMO and Lead Clinician. Professor Thomson and Mr Richards each confirmed that they would have been supportive of the local decision-making if they had been involved directly.

Mr Crichton underlined this point, and that these incidents happened across a short interval of time and were unusual in that respect. There had been a senior presence as outlined by Professor Thomson and the report provided reassurance on practice.

The Committee were content to note the report.

NOTED

14 CLINICAL GOVERNANCE ANNUAL REPORT AND STOCK-TAKE

A report was submitted to the Committee, on behalf of the Medical Director, which provided an overview in respect of the Clinical Governance Committee Annual Stock Take, and which outlined the wide range of activity overseen by the Committee during 2017/18.

Professor Thomson summarised the report and Members noted in particular the introduction of discussion topics to the Committee which had been a positive development. Members responded positively to the structure of the report and that the workplan to be clear and to cover relevant areas in which the Committee had oversight.

NOTED

15 DISCUSSION: SUICIDE PREVENTION & SELF HARM

This item was deferred due to time constraint and would be brought back to the Committee at the next meeting.

NOTED

16 AREAS OF GOOD PRACTICE / AREAS OF CONCERN

The Committee noted the ABOL project undertaken by Infection Control as an area of good practice; and compliance for training modules as an area of concern. Both issues should also be shared with the Staff Governance Committee.

Action – M Smith

17 WORKPLAN

It was noted that the workplan should be updated to reflect the deferral of item 15 from this meeting.

Action – S Smith

18 ANY OTHER BUSINESS

There were no other competent items of business for discussion

19 DATE AND TIME OF NEXT MEETING

The next meeting would take place on Thursday 9 August 2018 at 9.45am in the Boardroom, The State Hospital, Carstairs.

The meeting concluded at 12.20pm

Board Paper 18/33

NHS SCOTLAND

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	28 June 2018
Agenda Reference:	Item No: 12
Sponsoring Director:	Chief Executive
Author(s):	Interim Director of Human Resources
Title of Report:	Workforce Plan 2016-2021 – Update 2018
Purpose of Report:	Update on progress 2018

1 SITUATION

The State Hospital Board (TSH) is required to submit an annual Workforce Plan to the Scottish Government in line with the "Revised Workforce Planning Guidance", CEL 32[1]. A five year Workforce Plan (2016 -2021) http://www.tsh.scot.nhs.uk/Board/Papers.html was developed and submitted in June 2016. This described the anticipated changes faced nationally and locally and identifying potential strategic actions needed to deliver the Board priorities. This report outlines the progress made as at March 2018.

In addition SGHD have issued an online workforce projections template for 2018/19 which will be populated locally with the Board's baseline data as at 31st March 2018 and the ISD baseline date. The workforce projections will be based on workforce changes that have been endorsed by governance groups and are in line with the financial plan.

2 BACKGROUND

The State Hospital Board's workforce will continue to be instrumental in the successful delivery of our service priorities through making best use if the skills and capabilities of its staff. The workforce, in all professions and at all levels, have a part to play and staff will be supported and developed to ensure they can fully engage and commit to the service delivery model.

Key workforce work streams identified to improve service delivery include:

- Nursing
- Administration
- Physiological Therapies
- Shared Services
- Security

3 ASSESSMENT

Workforce Work streams
The Staff Governance Standard provides the organisation with a platform to drive improvements in the management of staff. Our staff governance action plan identifies important actions we plan to take to ensure that the five objectives of the standard are met.
The staff governance action plan includes plans to achieve national targets such as:

- Management of sickness absence within 5% (4% national standard).
- All staff will have an annual Personal Development Planning and Review meeting with their line manager.

In addition to working towards the achievement of these standards, there are a number of local priorities which are important for 2018/19. The work streams identified have been progressed as follows:

Sustainable Workforce;

- To review nursing workforce capacity in relation to core service requirements - ongoing
- To review the Patient Day - ongoing
- To improve Staff Attendance – ongoing

Capable Workforce;

- To develop a Leadership Programme to nurture leadership skills and support workforce capability – commenced in respect of Senior Charge Nurse Development with principles being implemented across all leaders within the organisation
- To develop secondment opportunities within the Forensic Network - ongoing

Quality Improvement Skills:

- To Develop a QI Strategy - ongoing

Effective Leadership:

- To develop recommendations to improve the nursing management and leadership arrangements – part completed

These work streams have been conducted in partnership and take into consideration the mix of professional skills required to work with the patient population, and ensure that the Clinical Model can be successfully delivered in the short, medium and long term. In addition for 2018/19 the following workforce work streams will be progressed:

- Review of Administrative Services – Management Centre
- Nursing – Service and Sustainability – Legislative Provision on Safe Staffing
- Security
- Review of Psychological Therapies provision
- Ongoing CRES (Cash Releasing Efficiency Savings) position and future prediction of workforce requirements

Financial Context
The financial plan incorporates the Scottish Government Pay Policy which recommends a 3% pay increase for public sector workers earning £30,000 or less and a cap of 2% on the increased pay bill for staff earning more than £30,000. There will be a cap on pay applied for highest paid, with a maximum cash increase of £1,600 for those earning above £80,000. The final pay settlement for NHS staff will of course be subject to the NHS pay reviews process as in previous years.
The Scottish Government Budget reflects the commitment that more than half of frontline spending will be in community health services by the end of this parliament. The 2018-19 funding is designed to support a further shift in the share of the frontline NHS budget dedicated to mental health and to primary, community and social care. It is expected that NHS Boards and Integration Authorities contribute to this Programme for Government commitment and it will be essential that

this is clearly evidenced as part of plans for 2018-19. Whilst this is not directly relevant to this Board any opportunity to support this will be included within the Board financial and local delivery plans.
The key points from the Scottish budget announced that are reflected within the Board financial plans for 2018/19 are:

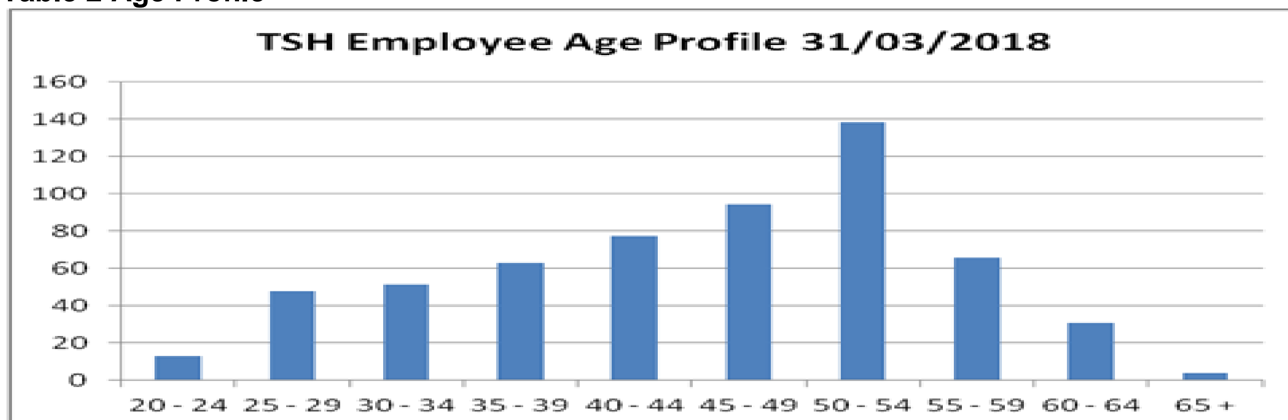
- The State Hospitals Board for Scotland will receive an uplift of 1%, similar to the other national 'patient facing' Boards
- The National Board savings requirement of £15 million in 2017-18 will be made recurring in 2018-19; the allocation of this to be agreed in advance of the new financial year.

Current Workforce
The TSH workforce as at 31st March 2018 equates to 585.5 WTE in-post staff. Since March 2017, the TSH workforce has decreased by 14.2 WTE.

Table 1 Gender Profile

The State Hospital				Whole time			Part time		
31/03/2018	WTE	Male	Female	Total	Male	Female	Total	Male	Female
	585.5	267.9	317.6	513.0	259.0	254.0	72.5	8.9	63.6
Medical	12.7	7.5	5.2	11.0	7.0	4.0	1.7	0.5	1.2
Nursing	339.3	186.4	152.9	333.0	186.0	147.0	6.3	0.4	5.9
AHP	12.3	0.5	11.8	8.0	-	8.0	4.3	0.5	3.8
Therapeutic services	14.8	2.9	12.0	11.0	2.0	9.0	3.8	0.9	3.0
Administrative	87.6	18.0	69.6	69.0	18.0	51.0	18.6	-	18.6
Support services	118.8	52.7	66.2	81.0	46.0	35.0	37.8	6.7	31.2

Table 2 Age Profile



National Workforce Planning
Boards are at early stages of national workforce planning but the existing relationships and collaborative working provides a strong foundation to build on. A National Workforce Profile Assessment is being developed and TSH will continue to play a pivotal role in this work.

National Health & Social Care Workforce Plan
The National Health and Social Care Workforce Plan - Part 1 and Part 2 were Published in 2017. Part 3 was published April 2018. The purpose of the National Workforce Plan for Health and Social Care is to enable better local and national workforce planning to support improvements in service delivery and redesign.

4 RECOMMENDATION

The Board is asked to note the update, approve the priorities for 2018/19 and the proposal to update the Staff Governance Committee at routine intervals.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Workforce Plan is integral to the achievement and delivery of the Board Annual Operational Plan.
Workforce Implications	Noted in the draft Plan.
Financial Implications	The Workforce Plan is directly linked to financial modelling described by the 2018/19 budget plan.
Route To Board Which groups were involved in contributing to the paper and recommendations.	Staff Governance Committee
Risk Assessment (Outline any significant risks and associated mitigation)	No significant risks identified.
Assessment of Impact On Patient Experience	None identified.
Equality Impact Assessment	No identified implications.

NHS SCOTLAND

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	28 June 2018
Agenda Reference:	Item No: 13
Sponsoring Director:	Interim Human Resources Director
Author(s):	Interim Human Resources Director
Title of Report:	Annual Report of the Staff Governance Committee for the Year Ended 31 March 2018
Purpose of Report:	For approval

1 SITUATION

The attached Staff Governance Committee Annual report outlines the key achievements and key developments overseen by the Committee during 2017/18. The stock take 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 2017/18, 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.

4 RECOMMENDATION

The Board is asked to note and agree the Staff Governance Committee Annual Report.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives?	
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
Risk Assessment (Outline any significant risks and associated mitigation)	n/a
Assessment of Impact on Stakeholder Experience	n/a
Equality Impact Assessment	n/a

THE STATE HOSPITALS BOARD FOR SCOTLAND

STAFF GOVERNANCE ANNUAL REPORT

1 April 2017 – 31 March 2018

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 2017/18, 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 2017/18 are detailed below.

2. Committee Chair Members and Attendees

Committee Chair:
Bill Brackenridge (Chair of Committee, Non Executive Director)

Committee Members:
Nicholas Johnston (Non Executive Director)
Maire Whitehead (Non Executive Director)
Anne Gillan (Employee Director)
Donald Speirs (lay member, Royal College of Nursing)
Alan Blackwood (lay member, Prison Officers' Association)
Tom Hair (lay member, UNISON)
Robert Alexander (Clinical Operations Manager)

Attendees:
Terry Currie (Chairman)
Jim Crichton (Chief Executive)
John White (Interim Human Resources Director)
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, presentations etc.

3. Meetings during 2017/18

During 2017/18 the Staff Governance Committee met on 4 occasions, in line with its terms of reference (appendix 1). Meetings were held on:

1 June 2017
17 August 2017
30 November 2017
1 March 2018

4. Reports Considered by the Committee During the Year

The Committee received reports and monitored areas as follows:

- Staff Governance Self Assessment Submission 2016/17
- Monitoring of Knowledge and Skills Framework performance
- Annual Submission to Scottish Government of mandatory workforce statistics.
- Monitoring of Attendance Management performance
- Implementation of the 2020 workforce vision
- Monitoring the content and actions relating to Audit Reports covering Staff Governance matters
- Monitor the implementation and consider the outcome of iMatter, the NHS Scotland Staff Engagement Tool

4.1 Annual Reports

Staff Governance Action Plan submission 2016/17

The Staff Governance Action Plan return for 2016/17 provided assurance that The State Hospitals Board for Scotland had met its obligations under the Staff Governance Standards. Feedback from Scottish Government contained the following comments:

- In terms of overall experience of staff the Board were congratulated on the significant improvements which had been made as a result of the improvement work undertaken
- In terms of well informed the Board were again congratulated on the variety of methods adopted to communicate with staff
- In terms of appropriately trained and developed the Board were congratulated on our ongoing achievements in relation to KSF Reviews and PDP where the achievement of 84.7% completed annual reviews by March 2018, represents an increase of 11.4% from the previous year.
- There was a need to improve upon the area of staff feeling involved in decisions, dignity at work issues and staff feeling able to speak up and challenge

Staff Governance Action Plan 2017/18

The Action Plan for 2017/18 focused on outcomes relating to the priorities within Everyone Matters 2020 Vision relating to Healthy Organisational Culture, Sustainable Workforce, Capable Workforce, Integrated Workforce and Effective Leadership and Management. Main priorities/actions are detailed below:

- Implementation of Cycle 3 of iMatter
- To embed NHS Scotland values within the Board
- Improve performance in attendance management
- Tackling bullying and harassment within the workplace and ensuring all staff are treated with dignity and respect:
- Ensuring effectiveness of communication with staff and involvement in changes which affect them within the organisation.

- Addressing issues relating to Health, Safety and Wellbeing of staff
- Participation in the National Shared Services agenda as appropriate
- Scope progress with regard to review of PIN policies

With particular reference to the work undertaken for the Staff Governance statutory requirements, all processes were undertaken within the necessary timescales.

The Human Resources and Partnership Working Group, comprising a range of operational managers, staff side representatives and HR staff, continued to work closely with Partnership Forum colleagues to develop and approve policies relating to staff governance.

Occupational Health Service Annual Report

The annual report was presented by the Occupational Health Clinical Team from SALUS, current provider of the OHS service level agreement at the November 2017 meeting.

4.2 Progress Updates

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

- Knowledge and Skills Framework
- Attendance Management

The Committee had a particular focus on the performance of the organisation in relation to attendance management. Additional reports were requested by members relating to an analysis of the highest level of absence experience in year along with further data in respect of the application of the Attendance Management Policy.

Knowledge and Skills Framework

Monitoring of the completion rates for Personal Development Plans for staff was kept under scrutiny all year and reported monthly to the Senior Management Team. The average monthly completion rate was 84.5%.

Attendance Management

The State Hospitals Board for Scotland did not achieve the absence management standard of 5% in 2016/17. The end of year average absence percentage was 8.35%.
The principal reasons for absence remained consistent with the previous year, with the two most common reasons for absence being anxiety/stress/depression and musculoskeletal conditions.

As previously stated the Committee paid particular attention and applied more scrutiny to this issue throughout the year and wished to be assured that all steps were being taken to reduce the level of absence being experienced.

4.3 Standing Items Considered by the Committee During the Year

Workforce Plan

The Committee monitored progress in the achievement of workforce plan targets.

Fitness to Practise

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

Dignity at Work

Training for managers was carried out in line with the corporate training plan on the Prevention and Management of Bullying and Harassment. This involved the provision of Emotional Intelligence training which was well received by staff.
Members were also assured that the recording arrangements for all Employee Relations matters including Dignity at Work had been reviewed to ensure that all of the relevant data is captured.

2020 Workforce Vision

The implementation plan for 2020 workforce vision generated much debate, and informed the planning process for the Staff Governance Action plan 2017/18.
The Committee received and noted minutes of the following committee meetings:

- Partnership Forum;
- Health and Safety Committee;
- Clinical Governance papers (as appropriate and where related to a Staff Governance issue);

Mandatory and Statutory Training

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

5. Conclusion

The performance year 2017/18 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. In addition another priority is the completion of Personal Development Plans. Performance in these two areas will continue to be monitored rigorously by the Committee in the coming year against the background of the new approaches which have been developed and are being adopted to address these priorities.

From the review of the 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 2017/18.

NHS SCOTLAND

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

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 submitted for approval at the next Board meeting. The Chief Executive's personal assistant is responsible for minute taking arrangements.

Following approval by the Board, minutes of the Staff Governance Committee will be presented to the next Staff Governance Committee meeting to ensure actions have been followed up.

The draft minutes will be cleared by the Chair of the Committee and the nominated lead Executive prior to submission to the Board.

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 Executive 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, by presenting the minutes of the Committee for approval.

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.

NHS SCOTLAND

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	28 June 2018
Agenda Reference:	Item 14
Sponsoring Director:	Interim Human Resources Director
Author(s):	Interim Human Resources Director
Title of Report:	Annual Report of the Remuneration Committee for the Year Ended 31 March 2018
Purpose of Report:	To note and approve

1 SITUATION

To provide a report containing a summary of the work overseen by the Remuneration Committee. The attached Remuneration Committee Annual report outlines the key achievements and key developments overseen by the Committee during 2017/18. The stock take also includes the Committee's Terms of Reference, Reporting Structures and Work Programme.

2 BACKGROUND

The Staff Governance Standard 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**.**

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

- 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 remuneration committee.

3 ASSESSMENT

This report outlines the work of the Remuneration Committee as it seeks to support the State Hospitals Board for Scotland's aim to be an exemplar employer with systems of corporate accountability for the fair and effective management of all staff, with particular regard to the pay, performance and terms and conditions of Executive and Senior Managers.

The Remuneration Committee reports to the Audit Committee. The committees Terms of reference are subject to annual review. The programme of work is largely determined by the requirement to implement executive and senior managers pay with reference to relevant SGHD instruction and performance appraisal. In addition oversight of the application and award of discretionary points is a routine consideration of the committee as is consideration of ad-hoc issues relating to remuneration.

4 RECOMMENDATION

The Board is asked to note and approve the Remuneration Committee Annual Report.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives?	
Workforce Implications	n/a
Financial Implications	n/a
Route To Board Which groups were involved in contributing to the paper and recommendations?	n/a
Risk Assessment (Outline any significant risks and associated mitigation)	n/a
Assessment of Impact on Stakeholder Experience	n/a
Equality Impact Assessment	n/a

THE STATE HOSPITALS BOARD FOR SCOTLAND

REMUNERATION COMMITTEE ANNUAL REPORT

1 April 2017 – 31 March 2018

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 2017/18, 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.

2 COMMITTEE CHAIR MEMBERS AND ATTENDEES

Committee Chair:
Terry Currie, NHS Board Chair

Committee Members:
Maire Whitehead, Non-Executive Director
Elizabeth Carmichael, Non-Executive Director
Bill Brackenridge, Non Executive Director
Nicholas Johnston, Non Executive Director
Anne Gillan, Non Executive Director / Employee Director

Attendees:
Jim Crichton, Chief Executive
John White, Interim HR Director
Jean Wade, Board Secretary (part year)
Margaret Smith, Board Secretary (part year)

3 MEETINGS DURING 2017/18

During 2017/18 the Remuneration Committee met on four occasions, in line with its terms of reference. Meetings were held on:

- 29 June 2017
- 24 August 2017
- 7 December 2017
- 15 February 2018

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 2016-17.

- Agreement that the Appraisal outcomes for Executive Directors be submitted to the National Performance Management Committee. Also consideration of the National Performance Management Committee's appraisal analysis.
- Agreement of the Executive Directors Performance Planning and Review (Objectives) for the year 2017/18.
- Consultants discretionary points were reported on and approved.

5 CONCLUSION

The Remuneration Committee discharged its responsibilities with regard to the oversight of Executive and Senior Managers' performance management and remuneration. The Committee also reviewed a range of other issues as required during the reporting period.

I would like to thank the Committee members for their contribution to the meetings in 2017/18.

NHS SCOTLAND

THE STATE HOSPITALS BOARD FOR SCOTLAND *SG(M)1/01*

Minutes of the meeting of the Staff Governance Committee held on Thursday 5 April 2018 at 9.45am in the Boardroom, The State Hospital, Carstairs.

Present:

Non Executive Director	Bill Brackenridge ***(Chair)***
Employee Director	Anne Gillan
Non Executive Director	Maire Whitehead

In attendance:

POA Representative	Alan Blackwood
Chief Executive	Jim Crichton
Unison Representative	Tom Hair
Board Secretary	Margaret Smith
Interim HR Director	John White

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

Bill Brackenridge welcomed everyone to the meeting and noted apologies from Nicholas Johnston and Terry Currie. He noted that this meeting had been postponed from 1 March 2018, due to adverse weather conditions. He also wished to record the Committee's whole-hearted thanks and appreciation to all staff for their contribution to ensuring delivery of safe and effective care at The State Hospital (TSH) during this recent period of adverse weather.

2 CONFLICTS OF INTEREST

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

3 MINUTES OF THE PREVIOUS MEETING HELD ON 17 AUGUST 2017

The Committee approved the Minutes of the previous meeting held on 30 November 2017 as an accurate record.

4 ACTION POINTS AND MATTERS ARISING FROM THE PREVIOUS MEETING

Members noted that the Action Points from the last meeting were progressing or complete. Further advice was being sought by the Health, Safety and Welfare Committee in respect of item 4, relating to reversing vehicles in hospital grounds.

5 ATTENDANCE MANAGEMENT REPORT

The Committee received two Attendance Management Reports which proved an update for the periods 1 December 2017 to 31 January 2018. Mr White was in attendance to lead the Committee through the key issues in each report. He noted the improving position of TSH in comparison to the national data. It was acknowledged that there had been increases during this period in sickness absence, in particular with a January 2018 figure of 10.06%. Mr White advised that there was an indication of return to the overall downward trajectory with the figure for February 2018 expected to be 6.9%. He also highlighted the rate of compliance with EASY of 98% which represented an excellent result for the teams across TSH as a whole.

Mr Brackenridge welcomed this update, and advised that he was reassured to learn that sickness levels had decreased in February 2018 as that would represent the most improved position since May 2016.

Mr Hair asked whether it was possible to make a comparison between NHS organisations which were patient facing and those which were not i.e. was it the case that non-patient facing organisations demonstrated lower levels of staff absence rates. Mr White clarified that variance, to reflect the different environments within NHS organisations, was built into the methodology around factors given consideration in reporting data (and that this had last been reviewed in 2015). Mr Brackenridge noted that the average rates within private organisations would be expected to be at around 2%. Mr Hair considered whether it was possible to identify different strategies adopted by those organisations who were performing well within the national comparison, or if the variance could be entirely explained by different environments.

Mr Blackwood raised local experience around GP Fitness certificates, and whether it was possible to audit any pattern in periods of absence beyond management of individual staff members. Mr White noted that as an employer, the organisation was reliant on clinical professional guidance. At the same time, line managers could make referrals to Occupational Health for further guidance. Mr Blackwood thought it possible that there was a lack of awareness among staff that they could – should they feel ready – return to work before the end of the period stipulated in the GP Fitness Certificate. Mr White agreed that it could also be appropriate to challenge staff on an individual basis. The Committee considered that there could be an opportunity for the organisation to better equip line managers to have those types of conversations which could potentially be difficult. This was noted as an action for Mr White to consider and take forward with the Human Resources department.

Action – Mr White

Ms Gillan picked up on apparent low levels of staff indicating mental health issues as a reason for their absence, and raised a concern as to whether staff were accessing help appropriately. She asked whether it was possible to ask staff if they were seeking professional assistance outwith of the organisation. Mr White noted that it was not possible to ask staff whether they were doing so and this underlined the importance of ensuring that all staff were aware of the support mechanisms available to them. Mr Blackwood added that this was something line managers could do during the absence review process.

Mrs Whitehead asked whether there was reporting of data on absences which extended over 6 months, and Mr White confirmed that EASY reporting would encompass this.

Mr Brackenridge noted that the Internal Auditors had provided a report to the Audit Committee (along with an Action Plan) around sickness absences. It was agreed that this would be brought to the next meeting of the Staff Governance Committee, for their consideration and discussion. It was also agreed that going forward the Staff Governance Committee would receive any Audit Committee reports relating to this as well as any reports relating to workforce planning.

Action – Mr White/Ms Smith

NOTED

6 PERSONAL DEVELOPMENT PLAN

The Committee received the PDPR Update, which proved an update in relation to personal development planning and review compliance across TSH as well as implementation of the qualitative review action plan. The reports provided updates for the period 1 December 2017 to 31 January 2018. Mr White highlighted the high compliance rates of 89.1% and 89.9% for each month respectively which compared favourably to national compliance rates. Mr Brackenridge noted that these figures were a major achievement and congratulated staff on this.

Mr White reminded the Committee that the new national system – Turas – had been introduced on 1 April 2018, and that the roll out of training across the site had been commenced. He underlined that the competence levels measured through this new system were similar to the previous KSF system, in a more condensed format.

The report was received positively by the Committee.

NOTED

7 VALUES AND BEHAVIOURS REPORT

The Committee received an update report, which provided detailed background to the continuing work undertaken by this group to progress the Action Plan for 2017-18. Mr White highlighted the substantial efforts by the group in this area. In particular, work had been progressed to promote the four core NHSScotland values over the four quarters with TSH staff. It was recognised that this was a long term project and that the benefits of this would only be recognised over time.

Mr White also highlighted plan for a staff recognition scheme and discussed the proxy measures used to measure the embedding of these care values across the site whilst welcoming any new and helpful means of measuring change.

Mrs Whitehead asked for an update regarding progress towards a Learning & Development Awards Scheme and Mrs White confirmed that although this had not been possible by end of March 2018 as initially planned, this would be taken forward in the current year.

Mr Crichton commended the work of the Values and Behaviour Group and suggested that the organisation's core values should play a prominent part in the induction process for new members of staff. It was agreed that Mr White would review this aspect and take forward.

Action – Mr White

The Committee expressed support for the recommendations within the report:

- Senior Managers increase their visibility across the organisation with a view to supporting the key messages around the organisation's values
- Partnership Forum and Senior Managers support the organisational conversation and encourage all staff to participate.

NOTED

8 iMATTER

The Committee received a report which provided an update on the current status of iMatter within the organisation. Mr White led the Committee through the report, highlighting that TSH compared favourably in national comparisons on the key indicators.

He also outlined some of the key challenges faced over the coming months, particularly continuing to engage staff across the organisation in the process, to provide assurance that iMatter was helpful in delivering a better working environment for all. Mr Brackenridge welcomed the positive nature of the report and commended the work completed to date.

Mr Hair noted that the report indicated variance across the organisation in relation to quality of Action Plans, and noted that it may be helpful to share some anonymised samples of good practice. Given that the report had indicated that an area of improvement was "involvement in decision-making", he highlighted the need to encourage staff to participate in consultations. Mr White acknowledged that that this was an area for development and sensitivity should be shown to

the particular TSH environment, as well as the context of a similar pattern nationally.

The Committee noted that the report recommended that all Managers should engage their teams in the iMatter process, and monitor progress effectively; and that Senior Managers should continue to increase their visibility.

NOTED

9 HR PERFORMANCE – EMPLOYEE RELATIONS ACTIVITY

The Committee received a report which provided an update on Employee Relations Activity. Mr White explained that this report had been shared with the Partnership Forum and the Senior Management Team for discussion around the helpfulness of the data. This was with a view to condensing the data to provide a clear indication of performance.

Ms Gillan advised that it had been confirmed at the Partnership Forum that this work was in development. Mr Crichton emphasised the importance of quality improvement in this area within the context of a systematic approach.

Mr Blackwood raised the delays experienced in management of employee relations cases and asked if this was due to capacity issues. Mr White agreed that there had been an issue in this regard within Human Resources and that temporary support had been sourced via NHS Lanarkshire. It was important to clearly establish the data on performance in order to inform decision-making on capacity. Mr Brackenridge echoed this indicating it was important to ensure that sufficient support was in place from the Human Resources department in relation to the size of the organisation.

NOTED

10 SCOTTISH GOVERNMENT – ANNUAL REVIEW REPORT

The Committee received a copy of Scottish Government's correspondence which summarised the main points from the Annual Review at TSH on 28 September 2017.

Mr Crichton noted the positive nature of the feedback received from Scottish Government.

NOTED

11 EU CITIZENS WORKING IN NHS SCOTLAND

The Committee received a copy of correspondence from Scottish Government in relation to EU Citizens working for NHS Scotland, for information.

NOTED

12 HEALTH, SAFETY AND WELFARE COMMITTEE – APPROVED MINUTES OF MEETINGS HELD ON 10 OCTOBER & 5 DECEMBER 2017

Members received the approved Minutes of the Meetings of the Health, Safety and Welfare Committee which took place on 10 October and 5 December 2017.

The Committee noted the content of these minutes.

NOTED

13 PARTNERSHIP FORUM – APPROVED MINUTES OF MEETINGS HELD ON 21 NOVEMBER & 19 DECEMBER 2017, 16 JANUARY & 20 FEBRUARY 2018

Members received the approved Minutes of the Meetings of the Partnership Forum which had taken place on 21 November and 19 December 2017and 16 January and 20 February 2018.

Mr Crichton highlighted developments the National Boards Delivery Plan, with agreement confirmed at the meeting that took place on 19 December 2017 that he would meet with the Employee Director in this regard to ensure staff-side involvement in this regard.

Mr Richards advised that there had been focus on the Board's financial position as well as staffing levels in the meeting held on 16 January 2018. He noted the engagement that followed with joint staff side which led to the implementation of the recovery action plan. Ms Gillan noted that joint staff side had raised concern in respect of the lack of consultation. Mr Crichton added that all of the measures carried out had been on consensual basis and that staff support had been tremendous – this sentiment was very much echoed around the table.

Ms Gillan highlighted discussion during the meeting held on 20 February 2018 the difficulties experienced in developing a matrix on timelines for progress of employee relations cases. The Partnership Forum had received assurance from Mr White of the degree of focus within Human Resources in this area.

The Staff Governance Committee noted the content of these minutes.

NOTED

14 ANY OTHER BUSINESS

There were no other items of competent business.

15 DATE AND TIME OF NEXT MEETING

The next meeting would take place on Thursday 31 May 2018 at **9.45am** in the boardroom, The State Hospital, Carstairs.

NHS SCOTLAND

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	28 June 2018
Agenda Reference:	Item No: 17
Sponsoring Director:	Finance & Performance Management Director
Author(s):	Acting Head of Financial Accounts
Title of Report:	Annual Report of the Audit Committee
Purpose of Report:	For approval

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

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 for approval by the Board.

4 RECOMMENDATION

The Board is asked to approve the annual report of the Audit Committee.

APPENDIX 1

THE STATE HOSPITALS BOARD FOR SCOTLAND

ANNUAL REPORT OF THE AUDIT COMMITTEE 2017/18

1 Introduction

The Report is submitted to meet the requirements within the Audit 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.

2 Membership and Role of the Committee

Audit Committee Membership	Role
E Carmichael (Chair) W Brackenridge A Gillan M Whitehead	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 3 times during 2017/18.

3 Audit

External audit coverage of the Board was provided by Scott Moncrieff.

The Internal Audit service was provided by RSM.

4 Review of the Work of the Committee

The Internal Audit Operational Plan from RSM for 2017/18 was approved by the Committee at its meeting on 29 June 2017. 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 2017/18, the Committee met on three occasions: 29 June 2017, 14 September 2017 and18 January 2018.

During this period, 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 2016/17 from the Chief Internal Auditor.
- Received the Annual Report and audit certificate for the 2016/17 audit from Scott Moncrieff.
- 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 2016/17 National Fraud Initiative.
- Reviewed and noted the Policy Management update.
- Received national Audit Scotland reports and performance audit studies, relating to the Health Service and to the wider public sector.
- Reviewed and noted the report and planned actions on the Security Audit.
- Reviewed and noted update of Efficiency / Productivity / Best Value.
- 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 annual report on Risk Management.
- Endorsed the Risk Management Strategy.
- 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.
- Reviewed and noted update on Business Continuity Resilience arrangements.
- Submitted minutes of meetings to the Board throughout the year.
- Received updates from the Human Resources Director in relation to the progress on the Sickness Absence audit report.
- Reviewed and noted the Procurement Annual Report.
- Reviewed and noted the Corporate Risk Register.
- Reviewed and approved the Annual Audit Committee Assurance Statement to the Board.
- Reviewed external Audit Plan.
- Review and agreed Audit Committee Work Plan 2018

5 Corporate Governance

During 2017/18 the Board’s Internal Auditors reported on the following significant areas of work:

- Cyber Security
- Effective Rostering & Overtime Management
- Patients’ Funds
- Complaints System

- Sickness Absence Follow Up Review
- Follow up of previous recommendations

6 Conclusion

Based on the work that it has undertaken, the Committee 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.

E Carmichael
AUDIT COMMITTEE CHAIR
On behalf of the State Hospitals Board for Scotland Audit Committee
28 June 2018

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives?	It is an important assurance process to the Board in considering the effectiveness of internal controls.
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 Acting Head of Financial Accounts and reviewed by Chair of Audit Committee
Risk Assessment (Outline any significant risks and associated mitigation)	No significant risks identified
Assessment of Impact on Stakeholder Experience	None
Equality Impact Assessment	No identified implications

NHS SCOTLAND

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	28 June 2018
Agenda Reference:	Item No: 18
Sponsoring Director:	Chief Executive
Author(s):	Chief Executive/Board Secretary
Title of Report:	International Travel Request

1 SITUATION

Requests for international travel require to be submitted to the Board for their approval.

2 BACKGROUND

The following request has been received. Line management approval has been given and costs are within budget.

Dr De Villiers has agreed to pay for flights meaning that it is the cost of the conference, accommodation at the conference centre, and subsistence only that would be claimed for.

EVENT/LOCATION	*DATE*	*STAFF INVOLVED*	*COST*
5th Bergen International Conference of Forensic Psychiatry – Neurocognitive Disorders Across the Lifespan.	23 - 25 October 2018	Dr Jana De Villiers, Consultant Psychiatrist – Clinical Lead for ID.	*£1064 (approx)

* This includes conference fee and accommodation.

3 ASSESSMENT

Many of the Hospital's Consultants and other staff are asked to present at Conferences and this is an opportunity to share best practice with colleagues from other organisations and to raise the profile of the work carried out within The State Hospital and the Forensic Network.

The 5th Bergen International Conference covers a broad range of topics, such as Autism, Intellectual Disability, Foetal Alcohol Syndrome and ADHD.

Dr De Villiers is Clinical Lead for Intellectual Disability and is seeking to develop services at The State Hospital to address the forensic aspects of neurocognitive disorders including the development of Foetal Alcohol Spectrum Disorder (FASD) Services.

This conference will provide Dr De Villiers with up to date research and clinical practice which in turn will inform clinical practice at The State Hospital and across the Forensic Network. Dr De

Villiers will share the knowledge gained with colleagues in the wider Hospital through the Journal Club lunchtime presentation meetings.

4 RECOMMENDATION

The Board is asked to approve the request received for international travel.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Monitoring of spend of staff requests for International Travel related to sharing of best practice, training and development.
Workforce Implications	N/A
Financial Implications	Monitored against relevant budgets – budget in place for all requests received.
Route To Board Which groups were involved in contributing to the paper and recommendations.	Requests received by Chief Executive. Board Members to consider at their next meeting thereafter.
Risk Assessment (Outline any significant risks and associated mitigation)	N/A
Assessment of Impact on Stakeholders	Learning shared across the organisation for the benefit of patient care.
Equality Impact Assessment	No issues

NHS SCOTLAND

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	28 June 2018
Agenda Reference:	Item No: 19
Sponsoring Director:	Director of Finance and Performance Management
Author(s):	Head of Management Accounts
Title of Report:	Financial Position as at 31 May 2018
Purpose of Report:	Update on current financial position

1 SITUATION

1.1 The Senior Team and the Board consider the Revenue and Capital plans, and financial monitoring. This report provides information on the financial performance to 31 May 2018, which is also on the Partnership Forum agenda.

1.2 Scottish Government requested a 1 Year Operational Plan (Narrative only – however, the financial template was still required for 3 Years), this also went to the April 2018 Board Meeting. This format is quite different to previous years (Local Delivery Plan 3/5 Years).

1.3 This Plan sets out a balanced budget for 2018/19 based on achieving £1.484m efficiency savings, as referred to in the table in section 4.
Recognition of recurring posts, saved through recent workforce reviews, or Utilities efficiency savings, amounting to £0.280m have already been realised in the 2018/19 base budget.
In effect, that brings the total savings target to £1.764m.

There is still a significant balance of savings not yet identified, this sits corporately until further discussions take place – the main reason for the gap is assuming the £0.440k reduction in 2017/2018 RRL is recurring (TSH contribution to Regional Savings).

2 BACKGROUND

2.1 Revenue Resource Limit Outturn
The Board is reporting an over spend position of £0.058m to 31 May 2018. The previous month was un underspend of £0.040m. The in month movement is £0.098m, primarily due to:-

- Nursing measures (now ceased) in March resulted in reduced overtime that month - which was paid in April. A group has been formed which will be addressing what is to be done to reduce overtime once again to a sustainable level on a longer term basis
- Utilities are underspent (seasonal).
- An amount is being accrued monthly pending pay award announcements.
- Unidentified savings now phased evenly throughout the year (actioned May).

2.2 **Forecast Outturn**

The forecast outturn trajectory to date is £0.034m underspend.
The YTD position at Month 2 is £0.058m overspent. Position is worse by £0.092m.
The monthly movement has come about with overtime rebounding in May as well as unidentified savings now phased from the start of the year rather than period 12.
The anticipated deduction of savings for Regional boards continues to have a major impact.

Expenditure Type	Annual Budget £'s	Year to Date Budget £'s	Year to date Actuals £'s	YTD Variance (budget less actuals) for period 2
Other Operating Income	(589,051.00)	(98,175.16)	(140,630.69)	42,455.53
Pay	29,132,289.00	4,791,099.54	4,799,170.48	(8,070.94)
Savings	(1,265,513.00)	(148,002.18)	0.00	(148,002.18)
Purchase Of Healthcare	800,585.00	133,430.83	121,080.33	12,350.50
Non Pay	4,707,004.00	735,374.73	710,680.58	24,694.15
Hch Income	(790,537.00)	(131,756.18)	(151,296.88)	19,540.70
Capital Charges	2,760,123.00	460,020.50	461,223.14	(1,202.64)
	34,754,900.00	**5,741,992.08**	**5,800,226.96**	**(58,234.88)**

2.3 **Revenue Resources**

The annual budget of £34.755m is the Scottish Government Revenue Resource Limit / allocation and anticipated monies.

3 **ASSESSMENT**
YEAR TO DATE POSITION BOARD FUNCTIONS

Directorates	Annual Budget 1819 £'k	YTD Budget May 18 £'k	YTD Actuals May 18 £'k	YTD Variance (budget - actual) May 18 £'k	Budget wte	Actual WTE
Cap Charges	2,760	460	461	(1)	0	
Central Reserves	(206)	(85)	84	(169)	0	0
Chief Exec	1,899	316	280	37	23.67	21.77
Finance	2,608	427	414	13	37.33	34.18
Human Resources Directorate	776	129	124	5	13.33	11.18
Medical	3,417	570	509	61	34.63	32.79
Misc Income	(130)	(22)	(3)	(19)	0	
Nursing And Ahp's	18,134	3,022	3,007	16	378.82	396.16
Security And Facilities	5,497	924	925	(1)	123.63	120.73
Under / (over) spend	**34,755**	**5,742**	**5,800**	**(58)**	**611.41**	**616.81**

3.1 **Capital Charges** no issues.

3.2 **Central Reserves / unidentified savings (phased to March 2019)** – the actual 'spend' is the accrual for the outstanding pay award.

3.3 **Chief Executive** –
HR Director secondment only being filled 0.50wte.
2.5ths of Finance Director to be recharged to Golden Jubilee.

Forensic Network & School of Forensic Mental Health sits within this Directorate, the Scottish Government earmark this funding. Some income has also been deferred from 2017/18, this is accrued monthly pending spend, to reflect the projected breakeven, there are also fluctuations due to timing of course income and expenditure, also accrued.

3.4 **Finance –** benefit from vacancies. Research under spent.

3.5 **Human Resources** – vacancies in various departments within the Directorate.

3.6 **Medical Services**
Specialty Doctor Vacancy.

3.7 **Miscellaneous Income** – includes RHI income.

3.8 **Nursing and AHPs**

Further detail has been provided on this Directorate.

Nursing & AHP's	Annual Budget £'k	Year to Date Budget £'k	Year to date Actuals £'k	YTD Variance (budget less actuals) for period 02 May 18	Budget WTE	Actual WTE
Advocacy	127	21	24	(3)	0	0
AHP's & Dietetics & SLA'S	607	101	78	23	13	9
Hub & Cluster Admin & Clinical Operations	762	127	138	(11)	23	24
Involvement & Equality & Pastoral	193	32	26	6	3	2
NPD & Infection Control & Clin Gov	386	64	62	3	6	5
Skye Centre	1,518	253	235	18	38	36
Ward Nursing	14,541	2,423	2,443	(20)	295	320
Total Nursing and AHP's	**18,134**	**3,022**	**3,007**	**16**	**378.82**	**396.16**

Advocacy – awaiting additional RRL from SG.

AHP's (Dietetics and OT) Vacancies.

Hub & Cluster Admin overtime.

I&E Vacancy.

NPD Vacancies.

Skye Vacancies.

Ward Nursing Improvement compared to last April, but has rebounded May 18, see table

below.

The pay/hours is for the previous months overtime/excess, e.g. April relates to March hours.

Memo: The pay award is not yet through so budgets have this included but actual pay does not – an amount has been accrued corporately (not by code), so this will have the position looking more favourable than it really should be, within Nursing especially.

The £'s includes NI'ers @ 11%

2018/19 Ward Nursing Hours		
Period	Overtime Hours	Excess Hours
APR	1,645	503
MAY	3,900	485
TOTAL	**5,545**	**988**

2018/19 Ward Nursing £s		
Period	Overtime £	Excess £
APR	41,056	7,981
MAY	100,150	7,945
TOTAL	**141,206**	**15,926**

The £'s includes NI'ers @ 11%

2017/18 Ward Nursing Hours		
Period	Overtime Hours	Excess Hours
APR	3,732	734
MAY	3,010	707
TOTAL	**6,742**	**1,441**

2017/18 Ward Nursing £s		
Period	Overtime £	Excess £
APR	93,077	11,283
MAY	75,198	10,553
TOTAL	**168,275**	**21,836**

3.9 **Security and Facilities**

Security & Facilities	Annual Budget £'k	Year to Date Budget £'k	Year to date Actuals £'k	YTD Variance (budget less actuals) for period 02 May 18	Budget WTE	Actual WTE
Facilities	3,998	666	644	22	84	79
Security	1,498	257	280	(23)	39.77	41.37
Total Security & Facilities	**5,497**	**924**	**925**	**(1)**	**123.63**	**120.73**

Facilities – Utilities under spent – timing.

Security – LTS quite high, backfill affect, also arrears paid (not funded yet).

4 EFFICIENCY SAVINGS TARGET

4.1 To balance the financial plan in 2018/19 the Board was required to release £1.764m of cash from budgets through efficiency savings, as noted in 1.3 above, £0.280m was recognised in the recurring base budgets, with £1.484m savings still to be realised in year.

4.2 The following table shows the savings still to be achieved in year.

Savings Annual Target LDP	Savings Annual Target LDP			Savings (Achieved) YTD, as at May 18			Savings still to be achieved by year end		
	2018-19 Rec £000s	Non-Rec £000s	Total £000s	2018-19 Rec £000s	Non-Rec £000s	Total £000s	2018-19 Rec £000s	Non-Rec £000s	Total £000s
Efficiency & Productivity Workstreams:									
Service redesign (Clinical)	5	0	5	0	0	0	5	0	5
Drugs & Prescribing	20	20	40	0	0	0	20	20	40
Workforce	244	588	832	243	156	398	1	432	433
Procurement	0	0	0	0	0	0	0	0	0
Financial management / corporate initiatives (Non Clinical)	29	47	76	19	0	19	10	47	57
Financial management / corporate initiatives (Non Clinical)	133	65	198	82	0	82	51	65	116
Other	0	100	100	0	0	0	0	100	100
Unidentified Savings	0	515	515	0	0	0	0	515	515
Total In-Year Efficiency Savings	**431**	**1,334**	**1,765**	**344**	**156**	**499**	**87**	**1,178**	**1,266**
£280k already achieved in base	Trajectory (1/12ths of LDP)			**72**	**222**	**294**			
	(under) / over achieved			**272**	**(67)**	**205**			

5 CAPITAL RESOURCE LIMIT

Capital allocations anticipated from Scottish Government amount to £0.269m, this does not recognise any funding for the Perimeter Fence.

	Annual Plan £'k	YTD Plan £'k	YTD Actual £'k	YTD Variance £'k
Estates	30	30	-	-
IM&T	30	30	-	-
Vehicles	-	-	-	-
Other equipment	209	209	-	-
Security Fence Dvpt	-		-	
TOTAL	**269**	**269**	**-**	**-**

6 RECOMMENDATION

6.1 **Revenue: Over spend of £0.058m.**

However, concerns should still be raised with the recurrence of the £0.440m territorial Boards savings deduction in 2018/19, also the levels of nursing overtime spend incurred previously will not be sustainable in 2018/19.

Quarterly Financial Review meetings, over and above the monthly Management Accounts meetings, help eliminate any surprises in the accounts and aids forecasting the year-end outturn. Savings are realised monthly and seem to be on track for the first couple of months, this is under strict scrutiny.

We are still predicting a year-end breakeven position.
The Board is asked to note the content of this report.

6.2 **Capital: No spend incurred yet.**

Our Head of eHealth is putting a bid to Scottish Government for additional funding for Data Centre Replacement; if this is successful then we will re prioritise other projects against the existing monies.

At this stage, we predict utilising the full allocation with a year-end breakeven position.
The Board is asked to note the content of this report.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Monitoring of financial position
Workforce Implications	No workforce implications – for information only
Financial Implications	No financial implications – for information only
Route to Board Which groups were involved in contributing to the paper and recommendations?	Head of Management Accounts
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

NHS SCOTLAND

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	28 June 2018
Agenda Reference:	Item no: 20
Sponsoring Director:	Finance and Performance Management Director
Author:	Angela Robertson
Title of Report:	LDP Performance Report 2017/2018 and Comparative Annual Figures.
Purpose of Report:	To provide KPI data and information on performance management activities.

1 SITUATION

This report presents a high-level summary of organisational performance for the year from April 2017 until March 2018 and is based on the Local Delivery Plan (LDP) and its associated targets and measures. The data for Q1-Q4 are reported to present an overview of performance over the year (Appendix 1).

The only national LDP standards directly relevant to the State Hospital are as follows: Psychological Therapies Waiting Times; GP access and Sickness Absence. Additional local KPIs are reported to the Board and included in this report. Going forward, the LDP process has been replaced by a requirement for each Board to submit an Annual Operational Plan for 2018-19. A review of the broader LDP standards is also being undertaken at a national level.

The figures from the previous two years have been included for comparison. The comparisons between the years have been made on the same periods – annual data against annual data, rolling figures against rolling figures etc (Appendix 2). It should be noted that due to the low number of patients, natural variations in the population can have an effect on the sample and small changes in our Key Performance Indicators (KPI) figures can look more significant when presented as percentages. These limitations should be borne in mind when considering this comparative data.

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

No 1 Patient have their care and treatment plans reviewed at 6 monthly intervals.

Performance has improved in 2017/18 and the figure for March 2018 was 95.4% (5 out of date, 1 due to a section change) compared to 91% in the previous year against a target of 100%. More robust systems are now in place with a future audit being planned to ensure the system is working efficiently at all points in the process – Health Records Department staff will work with Clinical Effectiveness and Medical Secretarial staff in this audit.

No 2 Patients will be engaged in psychological therapy.

Performance over the course of the year was consistently close to or above target. Psychological Therapy Services have been actively engaging patients in the last quarter to ensure that all patients are encouraged to participate in psychological therapies.

No 3 Patients will be engaged in off-hub activities.

Figures for Q4 were 77% compared to 76.3% in Q3. The average for 2017/18 was 78.7% against a target of 90% compared to the previous year's figure of 79.3%. These figures represent static performance for this target. The availability of activity was affected during the Q4 period by additional departmental closures as a consequence of the financial delivery plan and adverse weather conditions, which resulted in restrictions in patient movements for several days in March 2018.

No 4 Annual Physical Health Review and No 10 Access to Primary Care.

The Health Centre consistently meets its targets. The 48-hour access statistics are based on access to the appropriate healthcare professional, not solely the GP. Currently this would include the Practice Nurse, General Practitioners, Junior Doctors, Physiotherapist, Optician, Dental Team and NHS24.

No 5 Patients will undertake 90 minutes of exercise each week.

It is evident from Appendix 2 that the availability of reliable data about patients' physical activity has been a challenge for some years. The levels of patient activity within the Skye Centre could be monitored (i.e. Sports, Gardens and Fitness) but other opportunities were being missed. These included escorted walks, grounds access, outdoor gym and use of the ward/hub fitness equipment, as well as a variety of other activities.

However, there has been significant progress on this issue over the past year. The Physical Health Steering Group set up a Project Team including Clinical Staff and representatives from e-Health and the Skye Centre to develop and pilot a Physical Activity Monitoring System. Senior Management Team approved the process and it was implemented hospital wide during 2017-18. A physical activity form was developed within RiO that staff complete following any type of physical activity. This has, for the first time, facilitated comprehensive recording and measurement of physical activity. The Physical Activity Project Coordinator has monitored entries on a daily basis for accuracy, and to ensure that a minimum of two entries are recorded daily for each patient.

The data emerging is encouraging (average 48.7%, range 30.3%-58.5%). Data for the whole Hospital has only been available for a short time, there are fluctuations in what is being achieved, and the results may have been subject to constraints such as the adverse weather and financial delivery plan in Q4. In the longer term, the data will provide reliable insights at both population and individual levels into whether patients are meeting the current target and inform the development of new targets.

A new report is also being piloted that provides personalised analysis for individual patients, is easily accessible by all staff, and is incorporated into the weekly Clinical Team Meeting so that appropriate interventions can be set.

No 6 Healthier BMI.

The percentage of patients who have a healthier BMI increased from 13.6% in the previous year to 15.8%.

In 2017-18 the following actions were taken through the Supporting Healthy Choices Group to improve BMIs:

- Every patient receives an information pack on admission which includes information on nutrition, physical wellbeing and obesity risk factors.
- A new information sheet has been developed for carers and is included within each Carer Welcome pack.
- An electronic patient exercise recording system was successfully piloted and introduced throughout the hospital.
- Eight healthy wellbeing plans have been approved and will be implemented.
- A physical activity booklet had been produced and is being piloted.
- The Hospital Shop continues with its Healthy Retail Standards (80% healthy)
- External food procurement has ceased.

There is a work plan in place for 2018-19.

No 7 Sickness absence.

In the reporting period 1 April 2017 to 31 March 2018 the rate of absence was 8.52% compared to 8.35% in the previous year.

The financial year 17/18 saw sustained pressure on staffing as a direct consequence of sickness absence that significantly exceeds the required standard.

This has impacted negatively on the requirement for additional hours, with a subsequent pressure on front line staff to fill shifts, demands on staff to work additional hours, and a detrimental impact on budget. This has been an area of concern for the SMT and for the Board, with a new approach required to enhance governance and assurance in relation to these areas.

An improvement plan led by the Human Resources Director was commissioned by the Staff Governance Committee (August 2017) and has instigated a range of improvement measures. The specific aims identified for the Improvement Plan were:

- Identify for the committee, those policies and procedures relating to attendance management that were unfit for purpose.
- Identify for the committee those policies and procedures relating to attendance management that, currently, were not being fully implemented.
- Identify new initiatives that needed to be taken to bring attendance close to target in short order.

The improvement plan included a number of specific areas of work including:

- Improved Workforce Information to support managers identify trends and target interventions.
- Enhanced support for managers to ensure Policy Compliance.
- Enhanced Human Resource support for managers.
- OHS and EASY performance.
- Agreement on individual or collective actions.
- Employee engagement and responsibilities.
- Supplementary staffing alternatives.

Whilst there is early evidence of a reduction in absence from August 2017 onward, the improvement work will continue until this is sustained.

No 8 Staff have an approved PDP.

As of 9 April 2018, the total number of current (i.e. live) reviews was 508 meaning that 84.7% of staff met the standard of having had a performance development planning and review meeting conducted within the previous 12 months and having an up-to-date PDP in place compared to 73% in March 2017. 75 (12.5%) staff have an out of date PDP (i.e. the annual review meeting is overdue). 17 staff (2.8%) currently have no PDP.

As previously reported, a new national system for recording details of the KSF PDPR meetings has been introduced. The new system, called Turas Appraisal, officially went live on 2nd April 2018. The expectation is that the documentation for review will now be completed electronically and recorded within Turas Appraisal.

No 9 Patients are transferred using CPA.

97% of patients (30 out of 31) were discharged / transferred using the Care Programme Approach (CPA) against a target of 100%, which is a decline on last year's performance of 100%. The circumstances around the absence of a CPA for one patient resulted in a Significant Untoward Incident (SUI) review and learning points have been agreed.

Health Records previously provided a list of court dates in the same way they do for MHTs but this stopped some time ago. Whilst there is not a formal mechanism to robustly advise Social Work of pending court dates, the team have engaged with colleagues in Security who provide advance notice, when available, of forthcoming court dates. These are scanned with a view to identifying any that might suggest a risk of unplanned transfer/discharge. This allows consideration of the need for contingency planning, possibly invoking the Emergency Discharge Protocol.

The Social Work team are encouraged to be vigilant, and to discuss with the Management Team if they have any reason to suspect that a patient is at risk of unplanned discharge.

No 10 – refer to No 4.

No 11 Patients will commence psychological therapies <18 weeks from referral date.

All but one patient commenced treatment within this timescale in the course of the year.

No 12 Patients will engage in meaningful activity on a daily basis.
No 13 Hubs have a monthly community meeting.

Indicators 12 and 13 are to be replaced. The Director of Nursing and AHPs advises that new indicators and business processes are in development and will be reported on to test out their validity as measures. The proposed KPIs are as follows.

New KPI: A monthly feedback meeting takes place in each Hub and in the Skye Centre, which explicitly covers patient and carer feedback received and the action taken in response to same.

The learning from feedback report is available to all Clinical Leads, Skye Centre Manager and Lead Nurses through being members of SMT. A new Hub Operational Policy was approved by the SMT in April 2018. This clarified the role of the Hub Leadership Teams in considering data regarding service delivery, including learning from feedback.

Clinical Effectiveness has been asked to audit the work of the HLTs in July 2018.

New KPI: All patients will have a minimum of a weekly one to one discussion with their key worker documented in their records.

A function has now been introduced to RiO to record key worker 1:1 discussions. The current programme of audit only covers evidence of ongoing discussion between the patient and key/associate worker about the patient's care and progress. Work has commenced to adjust the audit to ensure monitoring and reporting is aligned with this KPI.

New KPI: The percentage of patients attending annual and intermediate CPAs

Data is sourced from Clinical Effectiveness who already produce this information for the Clinical Outcome Indicators report to the Clinical Governance Group and it is reported through the monthly VAT process.

This high level data will be reported to the Board as a trend over time given the difficulty in determining a hard target at this point (i.e. the ability, appropriateness or willingness of patients to attend full review etc). However, the comparative data across hubs that is already produced (and demonstrates significant differences in practice) is now being fed into the newly established Hub Leadership Teams for their consideration and response.

No 14 Patients will have their clinical risk assessment reviewed annually.

Performance has remained only slightly below the 100% target throughout the year. The figure for March 2018 is 99.1% with only one out of date, compared to 97% in March 2017. The system put in place from April 2017 has worked well over the past year and clinical risk assessments are now being completed timeously and in line with significant dates for each patient (e.g. date of renewal of detention or annual report). Monitoring and auditing of this system are ongoing.

No 15 Attendance by clinical staff at case reviews.

The table below provides comparative data on the extent to which professions met their Local Delivery Plan attendance target.

LDP Target	Target	17/18	16/17	Increase/decrease
RMO	90.0%	94.8%	96.8%	-2.2%
Medical	100.0%	97.5%	99.5%	-2.0%
KW/AW	80.0%	75.2%	71.8%	3.2%
Nursing	100.0%	96.4%	97.3%	-0.9%
OT	80.0%	65.5%	47.9%	17.6%
Pharmacy	60.0%	57.2%	74.5%	-17.8%
Clinical Psychologist	80.0%	69.6%	72.3%	-2.7%
Psychology	100.0%	90.8%	96.2%	-5.4%
Security	60.0%	59.8%	59.6%	0.2%
Social Work	80.0%	79.9%	75.5%	4.4%

Occupational Therapy – the new Lead Occupational Therapist came into post in September 2017. The service has prioritised attendance at case review and uses the VAT reporting at team meetings to explore solutions to attendance. One Occupational Therapist is on maternity leave, which will account for the shortfall in the target but it is hoped that this can be improved on for 2018-19.

Pharmacy – The overall decrease in pharmacy attendance at case reviews for the year was due to a staff vacancy between June 2017 and October 2017. This resulted in dropping below the attendance target over the first two quarters. Core service cover was however provided by other means at this time. NHS Lothian, who provide Pharmacy Services to The State Hospital, did give financial re-imbursement for the period of reduced cover. Recruitment in October 2017 returned the attendance level above the target for the remaining two quarters of the year.

Clinical psychology and psychology - The Psychological Therapies Service (PTS) had several long-term absences including injury and bereavement, and this affected attendance at case reviews in one hub in particular. This has now resolved and it is anticipated that the PTS will return to its previous levels of attendance at the case reviews.

Security – Performance has been maintained through the year with the target effectively being met, though there has been retirals and recruitment in the team leading to periods when some hubs were without a Security Manager for a period.

Social work – Whilst the overall Social Work attendance at case reviews has increased from 75.5% in 16/17 to 79.9% in 17/18, it is acknowledged that Q4 is the only one where the LDP target was not met. Whilst annual leave, other commitments and training will inevitably impact on the performance at times, it has been reinforced to staff that the VAT must be completed in all instances and that a reason must always be provided in the event that they are unable to attend their patient's case review.

It is also noted that the first quarter of the year traditionally has a higher than usual level of staff annual leave, as remaining entitlement from the previous year is used up. The management continue to monitor annual leave, to ensure adequate cover is maintained at all times.

4 RECOMMENDATION

The Board is asked to **note the contents of this report.**

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives?	Monitoring of Key Performance Indicator Performance in the TSH Local Delivery Plan (2017-2020).
Workforce Implications	No workforce implications-for information only.
Financial Implications	No financial implications-for information only.
Route to the Board (Committee) Which groups were involved in contributing to the paper and recommendations?	Leads for KPIs contribute to report.
Risk Assessment (Outline any significant risks and associated mitigation)	-
Assessment of Impact on Stakeholder Experience	-
Equality Impact Assessment	Not applicable.

APPENDIX 1

Key Performance Indicators

2017/18: Comparison across Q1-4

Item

Item	Principles	Performance Indicator	Target	Q1 Apr-Jun	Q2 Jul-Sep	Q3 Oct-Dec	Q4 Jan- Mar	LEAD
1	8	Patients have their care and treatment plans reviewed at 6 monthly intervals	100%	**99**	**97**	**96.3**	**95.4**	**LT**
2	8	Patients will be engaged in psychological treatment	85%	**91.8**	**94.5**	**84.5**	**94.4**	**MS/GM**
3	8	Patients will be engaged in off-hub activity centres	90%	**81.6**	**80**	**76.3**	**77**	**MR**
4	8	Patients will be offered an annual physical health review	90%	**100**	**100**	**100**	**100**	**LT**
5	8	Patients will undertake 90 minutes of exercise each week	60%	**New system being implemented 2017/2018.**			**48.7(range 30.3 – 58.5)**	**MR**
6	8	Patients will have a healthier BMI (bi-annual audit)	25%	**14.4**	**-**	**15.8**	**-**	**LT**
7	5	Sickness absence (National HEAT standard is 4%)	5%	**8.83**	**8.94**	**8.5**	**8.52**	**JW**
8	5	Staff have an approved PDP	100%	**80.4**	**87.2**	**89.5**	**84.7**	**JW**
9	1, 3	Patients transferred/discharged using CPA	100%	**100**	**100**	**100**	**85.7 (1/7 patients in Q4)**	**KB**
10	1, 3	Patients requiring primary care services will have access within 48 hours	100%	**100**	**100**	**100**	**100**	**LT**
11	1, 3	Patients will commence psychological therapies <18 weeks from referral date	100%	**100**	**100**	**99**	**100**	**MS/GM**
12	1, 3	Patients will engage in meaningful activity on a daily basis	-	**New indicators to be agreed.**				**MR**
13	2,6,7,9	Hubs have a monthly community meeting	-	**New indicators to be agreed.**				**MR**
14	2, 6, 7, 9	Patients have their clinical risk assessment reviewed annually.	100%	**96**	**98**	**97.2**	**99.1 (1 patient)**	**LT**
15		Refer to next table.						**All Clinical Leads**

Item	**Principles**	**Performance Indicator**	**Profession (Lead)**	**Target**	**Apr-Jun 2017**	**Jul-Sept 2017**	**Oct-Dec 2017**	**Jan-Mar 2018**
15	2, 6, 7, 9		RMO	90%	98%	96%	92%	94%
			Medical **(LT)**	100%	100%	96%	98%	96%
			Key Worker/Assoc Worker **(MR)**	80%	76%	64%	78%	82%
			Nursing **(MR)**	100%	96%	100%	92%	98%
			OT**(MR)**	80%	63%	55%	65%	78%
			Pharmacy **(LT)**	60%	49%	37%	69%	74%
			Clinical Psychologist **(MS)**	80%	65%	82%	59%	74%
			Psychology **(MS)**	100%	90%	98%	88%	88%
			Security**(DI)**	60%	43%	75%	57%	66%
			Social Work	80%	90%	80%	82%	68%
			Skye Activity Centre **(MR)** (only attend annual review)	tbc	0%	0%	3%	0%
			Dietetics **(MR)** (only attend annual review)	tbc	13%	0%	0%	0%

APPENDIX 2: KEY PERFORMANCE INDICATORS 2017-18 AND COMPARISION WITH 2016-17 AND 2015-16

Item	Principles	Performance Indicator	Target	RAG	17/18	16/17	15/16		LEAD
1	8	Patients have their care and treatment plans reviewed at 6 monthly intervals	100%	A	95.4%	91%	98%	*Figure to March each year.*	**LT**
2	8	Patients will be engaged in psychological treatment	85%	G	94.4%	96.4%	90.6%	*Figure to March each year.*	**MS/ GM**
3	8	Patients will be engaged in off-hub activity centres	90%	R!	78.7%	79.3%	81%	*Attendance averaged for the year.*	**MR**
4	8	Patients will be offered an annual physical health review.	90%	G	100%	100%	100%	*Figure for Apr 2017 - Mar 2018.*	**LT**
5	8	Patients will undertake 90 minutes of exercise each week (Annual Audit)	60%	-	Q4 only 48.7%	-	-	*New system fully implemented for Q4 2017/2018. (Range 30.3% – 58.5%)*	**MR**
6	8	Patients will have a healthier BMI	25%	R!	15.8%	13.6%	15%	*Figure from Dec 2017. Biannual audit.*	**LT**
7	5	Sickness absence (National HEAT standard is 4%)	** 5%	R!	8.52%	8.35%	8.03%	*Figure for April 2017-March 2018.*	**JW**
8	5	Staff have an approved PDP	*100%	A	84.7%	73%	82.7%	*Figure to March 2018.*	**JW**
9	1, 3	Patients transferred/discharged using CPA	100%	G	99%	100%	100%	*Figures for April 2017 - March 2018. 1 patient in year.*	**KB**
10	1, 3	Patients requiring primary care services will have access within 48 hours	*100%	G	100%	100%	100%	*Figures for April 2017 - March 2018.*	**LT**
11	1, 3	Patients will commence psychological therapies <18 weeks from referral date	**100%	G	100%	100%	100%	*Figure to March 2018.*	**MS/ GM**
12	1, 3	Patients will engage in meaningful activity on a daily basis	100%	-	-	-	-	*New indicators to be agreed.*	**MR**
13		Hubs have a monthly community meeting	100%	-	-	-	-	*New indicators to be agreed.*	**MR**
14	2, 6, 7, 9	Patients have their clinical risk assessment reviewed annually.	100%	G	99.1%	97%	97.3%	*Figure to March 2018. 1 out of date, reason unknown.*	**LT**
15	2, 6, 7, 9	Attendance by all clinical staff at case reviews	See above	-	57.9% overall	59% overall	59% overall	*Figures for April 2017- Mar 2018.*	**All Leads**

NHS SCOTLAND

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	28 June 2018
Agenda Reference:	Item No: 21
Sponsoring Director:	Finance and Performance Management Director
Author(s):	Head of eHealth
Title of Report:	eHealth Annual Report
Purpose of Report:	For noting

1 SITUATION

In order for the Board to have an overview of the work carried out by the eHealth Department, an annual report has been created for consideration of the Board members. The eHealth Annual Report aims to highlight the activities of the department during 2017/2018 while also detailing work required for 2018/2019.

2 BACKGROUND

The eHealth Annual Report aims to highlight the activities within the teams that make up the eHealth Department.

3 ASSESSMENT

The report highlights the main areas of activity and concerns form the previous year (2017-2018) The report has no impact on resources or finances for the department.

4 RECOMMENDATION

The Board is asked to **note** the attached report for the year 2017/18 in advance of its publication on the Hospital's internet web site.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives?	The Report follows good practice and also links in with the eHealth Strategy
Workforce Implications	Not applicable
Financial Implications	No financial implications if approved
Route to the Board (Committee) Which groups were involved in contributing to the paper and recommendations?	None
Risk Assessment (Outline any significant risks and associated mitigation)	No significant risks identified
Assessment of Impact on Stakeholder Experience	None
Equality Impact Assessment	No identified implications

THE STATE HOSPITALS BOARD FOR SCOTLAND

ANNUAL eHEALTH REPORT

APRIL 2017 - MARCH 2018

Responsible Director	Robin McNaught – Finance and Performance Management Director
Lead Manager	Thomas Best – Head of eHealth
Approved by	The State Hospital Audit Committee The State Hospital IT Sub Group
Date Approved	
Date for Review	28/6/18

Contents

1. Overview
2. Information Team
3. Infrastructure Team
4. Health Records Team
5. Project Team
6. Projects completed 2017 – 2018
7. Projects for 2018 – 2019
8. eHealth Collaborative Working

1 Overview

2017/2018 was a difficult period for the eHealth department. However, several large projects were delivered with varying degrees of success providing an overall outcome of a successful year for the department.

One of the biggest challenges was staffing. The essential appointment of an Information Governance and Data Security Officer left our Senior Infrastructure Team with one member fewer – which impacted on the management and maintenance of our computer infrastructure as well as the department's abilities to deliver service support. The service was further impacted due to sickness, and the departure of both members of the IT Helpdesk Team at the start of 2018.

The lack of infrastructure support staff had a substantial impacted on the priorities of the infrastructure teams. This also affected the infrastructure support provided to the organisation between January and April 2018.

Due to the successful recruitment of three new infrastructure support staff, the department is back to previous staffing levels, and we are now progressing work that had been put on hold while also taking forward the 2018/19 work schedule and projects.

2 Information Team

The eHealth Information systems team have been carrying out work to ensure that, where possible, the information gathered as part of our patients' care and treatment is stored electronically in our electronic patient records solution (EPR) RiO. They have worked closely with all disciplines within the hospital to develop electronic forms that capture the information needed to monitor the activities and recovery of our patients. Work recently completed and added to RiO include Physical Activity Recording and Reporting, Social Work Integration, Security Data Integration, an assessment form to streamline Clinical Team Meetings and Patient Weight Recording and Management.

The information systems team are also pivotal to the business intelligence project currently being developed prior to delivery. This project once completed will use Tableau business intelligence software to deliver graphical presentation of data recorded via patient care and activities. This project – once fully deployed – will provide visual representation of various data without the need to trawl through spreadsheets and databases. The first area this will address is nursing utilisation with a rollout to nursing and finance, and then to other departments within the hospital over the year.

3 Infrastructure Team

The Infrastructure team have been particularly impacted this year by absence and departures. They have however managed to maintain a significant level of infrastructure support to the organisation while also successfully delivering several key projects.

The scheduled and essential replacement of our network infrastructure did cause some initial problems, but these were overcome. This project delivered supported network equipment across the hospital with the addition of significant network security improvements and controls. The reasons behind these problems surfacing during the project have been identified and addressed.

Changes to project delivery have been agreed within eHealth and should ensure that the types of problems experienced by the network project should not be repeated with future major eHealth projects.

The delivery and implementation of the new patient movement and tracking system (PMTS) took significant involvement of the infrastructure team. The groundwork completed at the start of this project ensured the smooth and successful deployment of the PMTS. This ground work is now used as an example of how projects should be approached by all eHealth teams.

Cyber security has been at the forefront of everything we do for some time. However with last year's cyber attach on the NHS this area has the biggest workload for the hospital's infrastructure teams. After the cyber-attack we purchased and deployed anti ransomware software called InterceptX for all computers that connect to the hospital's network. This solution provides an additional layer of security across the network and will allow us to reverse the effects of certain types of computer viruses similar to the one that infected as a result of some NHS computer virus outbreaks last year. We are the first and only board so far to deploy this security product and it has now been identified as a possible ransomware solution to be deployed nationally across NHSScotland.

One of the most rewarding projects undertaken by the infrastructure team was the delivery of an iPad to enable staff to communicate effectively with a challenging patient. This required extensive testing before the security department would allow the device to be deployed. The feedback we have received has been very positive from the staff involved with the patients care and the patient. We are now looking at the potential of deploying secured iPads for patient internet shopping using the same technology.

4 Health Records Department

There has been significant work undertaken within the health records department to document processes followed when patients are admitted and discharged from the hospital. This work was undertaken after it was highlighted that only one individual in the organisation knew the processes but they had never been documented. The documentation now created has removed the dependency on one individual for this information, and also provides other health records staff with the knowledge to ensure all processes are followed as documented in order to maintain compliance with the Mental Health Act as well as departmental procedures.

The health records department are also significantly involved with developing and coordinating the hospitals records management plan, which has been a key element of GDPR. This work has been invaluable to all departments within the hospital and, when completed, they will have identified all the types of data held within the hospital as well as each data owner, the reason for the data's use, the relevant retention period and the expiry/deletion date if applicable.

5 Project Team

Our project manager has successfully brought in the Patient Movement and Tracking system (PMTS). They are supported by our Office Administrator who carries out a Project Administrator role when required.

They are at present working on the nursing utilisation resource business intelligence project.

Once this part of the project has been completed they will move on to the next area of work to utilise the reporting power of Tableau. There are several key projects to be delivered this year and the Project team will be extremely busy and well utilised.

6 Key eHealth Projects completed 2017 -2018

Patient Moving & Tracking System (PMTS)

Network replacement, network firewall, web filter and additional network security controls

Anti-malware protection to all computers

Mobile Device Management for the control and security of mobile devices

Secured iPad for use with patient care and recovery.

Ground work for Windows 10 & Office 2016 deployment

Cyber Resilience

7 Key eHealth Projects for 2018/2019

Storage and backup replacement

Patient Learning Centre infrastructure refresh,

Windows 10 & Office 2016 deployment

RiO EPR upgrade to version 7

Tableau business intelligence tool

Visitor booking system replacement

Cyber Resilience

8 eHealth Collaborative Working

The eHealth department represents the hospital at several national eHealth groups. This ensures we have sight of national programs and projects within NHS Scotland, and also highlights the potential of national solutions such as Tableau. This also allows us to benefit from national pricing on these products rather than going alone to procure services and solutions.

The groups on which State Hospital eHealth staff are represented are – eHealth Leads Group, National Infrastructure Group, National IT Security Group, National Board Digital Group, West of Scotland Infrastructure Group and the West of Scotland IT Security Group

Board Paper 18/42

NHS SCOTLAND

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	28 June 2018
Agenda Reference:	Item No: 22
Sponsoring Director:	Chief Executive
Author(s):	Chief Executive
Title of Report:	Foreign Travel Approval Arrangements for Forensic Network Staff
Purpose of Report:	For discussion / approval

1 SITUATION

The Forensic Mental Health Services Managed Care Network (Forensic Network) and the School of Forensic Mental Health (SoFMH) are hosted by The State Hospital (TSH) on behalf of Scottish Government.

Following a request by the NHS Board for greater clarity of governance arrangements regarding Foreign Travel Requests, this paper sets out a proposed process for approval of requests by staff employed on a full or part-time basis for the Forensic School or Network. It also clarifies the specific responsibilities of the NHS and Forensic Network Boards.

2 BACKGROUND

Origins Of The Network
The Forensic Mental Health Services Managed Care Network (Forensic Network) was established in September 2003, following a review of The State Hospitals Board for Scotland 'The Right Place-The Right Time'(Scottish Executive Health Department, 2002).

It was established to address fragmentation across the Forensic Mental Health Estate, to overview the processes for determining the most effective care for mentally disordered offenders, consider wider issues surrounding patient pathways, and align strategic planning across Scotland (Gordon, 2003; Scottish Parliament, 2003). Scottish Ministers requested that the Network bring a pan-Scotland approach to the planning of services and patient pathways, including the commissioning of research to establish an evidence base for future service development.

The Forensic Network also plays host to the School of Forensic Mental Health (SoFMH), which was established in 2007. It is a virtual School that is available to colleagues and associates from across the Forensic Network to assist with any teaching, training and research needs. The SoFMH has access to many experienced professionals and can support services in the development of teaching materials, courses or research in the field of forensic mental health services. The model involves expert clinicians, active in the forensic field, developing and delivering short courses in multi-agency fora.

Governance Arrangements
The primary method of governance is through the coordination of a national oversight group known as the Forensic Network Advisory Board. The advisory board is multi-agency and multi-disciplinary, containing representatives from TSH, Health Boards, Prisons, Police, Scottish Government, third sector partner agencies, and the chairs of professional groups. The Inter Regional Group was established to support the Forensic Network Advisory Board to develop national operational working throughout the forensic estate, to coordinate and implement the decisions of the Forensic Network Advisory Board, and to achieve the Forensic Network's aims. It bridges the gap between strategy and policy arising from the work of the Forensic Network Advisory Board, and operational and clinical activity within forensic units. Its membership is made up of regional leads and lead clinicians across the three Scottish regions (North, South East and West), and representatives from the TSH.

The SoFMH is governed by the School Governance Committee, a multi-disciplinary and multi-agency body with representatives from higher secondary education establishments. There is also an operational team who meet bimonthly and are responsible for the day-to-day running of the school. This operational team report to the School Governance Committee.

3 ASSESSMENT

The Board currently has a Policy of Staff Travel Expense Claims which outlines the requirement for Board approval for all staff requesting support for foreign travel / accommodation and conference costs.

> *Foreign travel is normally defined as being travel outwith the United Kingdom (UK), however under the Consultants Contract Terms & Conditions foreign travel is defined as travel outwith the European Union (EU).*
>
> *The Board requires that Medical Staff whose remuneration is determined by the Consultants Contract Handbook and Associate Specialist Contract / Terms & Conditions of Service will STILL require to obtain Board approval if travelling outwith the UK.*
>
> *All employees (including Senior Managers) requesting to travel outwith the UK, must obtain Board approval prior to making any bookings. The Board has delegated this authority to the Chairperson for approving.*

Given the unique duality of governance arrangements for the Forensic Network between the Forensic Network Board and the NHS Board, and the very specific nature of the Forensic Network in terms of education and research, the following process is recommended for applications from network or SoFMH staff:

1. That the requirement and rationale for the travel is made to the Chair of the Forensic Network Board for approval.

2. That the application has the support of the Chief Executive who (as the Accountable Officer) will validate that there is sufficient budget to support the application.

3. That the booking process for flights and accommodation will be through State Hospital procurement as normal.

4 RECOMMENDATION

The Board is invited to approve the amended arrangements for future travel request.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	N/A
Workforce Implications	N/A
Financial Implications	Cost neutral
Route To Board Which groups were involved in contributing to the paper and recommendations.	Via Chief Executive Officer and Medical Director
Risk Assessment (Outline any significant risks and associated mitigation)	None identified
Assessment of Impact on Stakeholder Experience	N/A
Equality Impact Assessment	N/A

NHS SCOTLAND

THE STATE HOSPITALS BOARD FOR SCOTLAND *A(M)18/02*

Minutes of the meeting of the Audit Committee held on Thursday 5 April 2018 at 9.45am in the Boardroom, The State Hospital, Carstairs.

PRESENT:

Non Executive Director	Bill Brackenridge
Non Executive Director	Elizabeth Carmichael **[Chair]**
Non Executive Director	Maire Whitehead

IN ATTENDANCE:

Internal

Chief Executive	Jim Crichton
Board Chair	Terry Currie
Employee Director	Anne Gillan
Information Governance and Data Security Officer	Ken Lawton
Finance and Performance Management Director	Robin McNaught
Board Secretary	Margaret Smith
Interim HR Director	John White

External

Senior Manager, RSMUK	Asam Hussain
Director, Scott-Moncrieff	Karen Jones
Head of Internal Audit, RSMUK	Mark Mazzucco

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

Mrs Carmichael welcomed everyone to the meeting. Apologies for absence were noted from the Board Chair, Mr Currie. Mrs Carmichael noted that recent period of adverse weather and wished to note the Audit Committee's thanks and appreciation to all staff who had made such great efforts to continue to deliver safe and effective care during this period.

NOTED

2 CONFLICTS OF INTEREST

There were no changes to the conflicts of interest noted at the last meeting. All conflicts declared would be held on record for the year. Any changes would be reported and recorded as they arose.

NOTED

3 MINUTES OF THE PREVIOUS MEETING

The Minutes of the previous meeting held on Thursday 18 January 2018 were approved. The Minutes had been submitted in draft to the Board Meeting for noting on 26 February 2018.

NOTED

4 MATTERS ARISING AND ACTION NOTES UPDATE

Members received and noted the Summary Action Points, and the progress made. It was noted that an update on effective rostering and overtime would be placed within a wider context of the measures taken to meet yearend balance for 2017/18 and be brought to the April meeting of the Board.

NOTED

5 ATTENDANCE MANAGEMENT UPDATE

The Committee was asked to note a report from the Interim Director for Human Resources which provided an update on attendance at The State Hospital (TSH) and placed this within a national context. Mr White highlighted the key points for Members, particularly the increase in the absence figure for January 2018. Mr White provided a further verbal update which indicated that this figure had improved and showed a decrease for February 2018. He also highlighted the continued excellent performance of EASY compliance.

Mrs Carmichael thanked Mr White for his report and noted that it was essential to focus on any long term trends. The Committee discussed the detail around the main reason for staff absence over the reported periods noting the possible impact of seasonal illness. There was further discussion around apparent differences in the reasons given for absences in the breakdown between monthly and yearly reporting which may merit further review.

The Committee noted that report and that although staff absence rates had increased in the short term, an improvement was noted for February 2018 which may be indicative of improvement over the longer term. The Committee would keep this under review, whilst noting that a six monthly report from EASY data would be channelled through the Staff Governance Committee who had oversight in this area.

NOTED

6 GDPR UPDATE

The Committee was asked to note a report from the Director of Finance and Performance Management which provided Members with an update on the progress made by TSH toward readiness for the legislation coming into effect on 25 May 2018.

Mr Lawton was in attendance to summarise the report for the Committee, and to indicate the key areas in which work was progressing. He provided a detailed and comprehensive review of the paper, which contained a traffic light signalling of status in each relevant area and this was received positively by Members.

Mrs Carmichael thanked Mr Lawton for his work, and for the clarity contained within the report. Mr Brackenridge echoed this and added that this report provided assurance and confidence in the work being progressed. He asked about the position in relation to historical data held which would not be appropriate under this legislation. Mr Lawton confirmed that a rolling review of patient records took place, with guidance from the Board's Caldecott Guardian. This led to a wider discussion round personal data and Mr Lawton guided Members through the application of the appropriate retention periods. In answer to a question from Mrs Carmichael around consent to hold details of and use personal emails, Mr Lawton confirmed that action was being taken to obtain consent and to issue privacy notices when appropriate.

The Committee noted this report and the good progress made to date and thanked Mr Lawton and the team for their work, which had provided the Committee with appropriate assurance in this area.

NOTED

7 ANNUAL INTERNAL AUDIT REPORT 2017/18

The Committee was asked to note a report from RSMUK which provided an annual internal audit opinion based upon and limited to the work performed, on overall adequacy and effectiveness of the organisation's risk management control and governance processes. The report indicated that the Board had an adequate and effective framework for risk management, governance and internal control. The report also indicated that further enhancement was required to ensure that this remained adequate and effective.

Mrs Carmichael summarised the productive nature of the past year, and the valuable nature of this work by RSMUK in challenging the organisation to continue to meet an appropriate standard.

NOTED

8 INTERNAL AUDIT – OBSERVATIONS TRACKING REPORT

The Committee was asked to note a report from RSMUK which tracked the progress the Board had made in implementing agreed management actions from previous internal Audit reports.

The Committee noted that the action point "Effective Rostering and Overtime Management Review" was overdue, although it was noted that an update would be brought to the Board Meeting on 26 April 2018. The Committee asked for this to be prioritised to ensure that the target was met.

Action – Mr Crichton

Mrs Carmichael asked for actions from external audit to also be included in the tracker document. RSMUK and Scott Moncrieff would liaise in this regard to ensure that the tracker was updated at appropriate intervals.

Action – RSMUK

NOTED

9 INTERNAL AUDIT PLAN 2018/19

The Committee was asked to note a report from RSMUK which outlined the internal audit plan for the Board for 2017/18. Key areas of potential risk were brought to the attention of Members including sickness and absence management, workforce planning review, patient activity review and the major capital project in respect of perimeter security.

It was noted that the dates of the Audit Committee for 2018 should be amended within the report.

Action - RSMUK

The Internal Audit Plan for 2017/18 was noted and agreed by the Committee.

AGREED

10 INTERNAL AUDIT PROGRESS REPORT

RSMUK submitted a summary update on progress made against the Internal Audit Plan for 2017/18, and a summary of the results.

The Committee noted that the plan had been completed, and that the plan for 2018/19 had been presented to this meeting.

NOTED

11 SICKNESS AND ABSENCE MANAGEMENT AUDIT REPORT

A report was submitted by RSMUK in relation to an audit of sickness and absence management as part of the approved internal audit plan for 2017/18. The report gave partial reassurance and outlined recommendations to be taken forward.

The report noted that THS had introduced new initiatives to improve absence management with the aim of reducing rates of absence gradually to achieve the Local Delivery Plan (LDP) target of 5%. However, the changes and improvement made required time to embed before evidence of the benefits would be evidenced. It was noted that testing against management of the Attendance Management Policy had not produced clear conclusions due to lack of data which was rooted in current lack of capacity within the Human Resources Department.

Mrs Carmichael thanked RSMUK for their report and added that, although enlightening, it was disappointing to find that it highlighted a lack of compliance across the wider context of line management within the hospital. The Committee went on to discuss the report's findings in detail.

Mr White advised that this result underlined the focus of the improvement plan, which when devised had found that compliance (and data to support same) were an area of focus for TSH. Work was being progressed within Human Resources (HR) to align departmental support to the different areas within the organisation. The HR Team was complete at the current time, which should allow this to be progressed.

Mr Brackenridge added that the lack of available data was of concern and indicated that line managers throughout the organisation needed further support to help them carry out this role. Mr White noted that SSTS could provide tools electronically to assist line managers.

As Chair of the Staff Governance Committee, Mr Brackenridge advised that further information in this regard should come to that Committee for review. In the meantime, it was agreed that a copy of this RSMUK report would be made available to the Staff Governance Committee.

Action: Ms Smith

Mr Brackenridge asked if there was sufficient HR capacity within workforce for the organisational need, and Mr White advised that there had been capacity issues due to sickness absence within the team.

Mr Crichton acknowledged that he shared the Committee's disappointment with the result of this report, and that focus around attendance management needs to be general throughout TSH. There had to be scrutiny in this regard, and although assurance had been provided in terms of continued focus, he recognised the need to ensure that the underlying evidence had to be there to allow any scrutiny process to be made. It was agreed that Mr Crichton and Mr White would review and provide an update in conjunction with the RSMUK report to the Staff Governance Committee at their next meeting on 31 May 2018.

Action – Mr Crichton/ Mr White

The Committee noted the report, the recommendations and the timescales for improvements. Whilst recognising that the sample size was small, the Committee was concerned at the significant gaps in data and at the problems with how hospital policies are being implemented. The Committee was looking for more substantial assurance that policies were appropriate and were being implemented and that improvements in recording and reporting data would be made. The Staff Governance Committee has a role in reviewing this going forward.

In addition, it was agreed that where audit reports were of interest to other Committees these would be provided to the Chair of the appropriate Committee to ensure good governance.

NOTED

12 WORKFORCE PLANNING REVIEW AUDIT REPORT

A report was submitted by RSMUK which provided internal audit opinion on workforce planning as well as recruitment process in the organisation

The report noted that TSH had been working on the implementation of a forensic workforce planning tool which NHS Boards across Scotland would have to implement – this would ensure safe staffing. The Workforce Plan 2017/20 highlighted key risk areas, but this was not subject to regular scrutiny through the Staff Governance Committee to ensure delivery of key actions. The audit also noted that analysis of the benefits of the closure of Mull 3 had not been fully completed.

The report gave the Board reasonable assurance that the controls in place to manage this area were suitable designed and consistently applied and identified areas of risk and for improvement.

Within recruitment processes, it was noted that the audit trail was poor, and that only partial assurance could be given to the Board in this area. Again, the Committee discussed the issues around the clarity of procedures and compliance and agreed that action was required to strengthen the control framework.

Mr Brackenridge agreed with the recommendation that the Staff Governance Committee should have an overview of workforce planning. There was discussion around this encompassing the impact of ward closure (Mull 3) during 2017. Mr Crichton added that there had been a re-fresh of the workforce plan in July 2017, and that further review should be routed through the Staff Governance Committee, and then to the Board for their oversight.

Action – Mr Crichton/ Mr White

The Committee discussed the legacy issues around the recruitment process, with variance across the site in the process used. Mr White advised that this would be given further focus and review within HR and that additional support was being provided by an HR Manager from NHS Lanarkshire in relation to audit issues. The Committee requested that an update report should be provided in six months.

Action – Mr White

The Committee noted that content of the report, the recommendations and timescales. There would be a report to the Board in respect of the impact of the closure of Mull 3 on workforce planning. The Staff Governance Committee would monitor the impact of the Workforce Plan, and an update report would come back to the Audit Committee in 6 months.

NOTED

13 eHEALTH IT HEALTHCHECK REVIEW AUDIT REPORT

The Committee received an advisory report from RSMUK which provided positive assurance and outlined several areas of good practice relevant to the unique circumstances of TSH. Systems were noted to be robust and that staff had the necessary experience to maintain these systems. Even with recent pressures on resources within the department, substantial progress had been made toward a more secure and stable IT environment since the issue of cyber security previously reported through KPMG. At the same time, it was noted that there was a risk to resilience with limited resources and the difficulty found in recruiting.

The Committee welcomed the report and noted their thanks to the eHealth department for their work. It was noted that the Head of eHealth would be in attendance at the next Board meeting to provide an Annual Report.

NOTED

14 EXTERNAL AUDIT – INTERIM AUDIT REPORT

Scott-Moncrieff Chartered Accountants submitted their interim audit report for the year ended 31 March 2018 which summarised the results of their review of the key financial systems. It was noted that action on one recommendation remained outstanding from previous years, and assurance was given that this would be completed by May 2018.

Ms Jones provided an update on preparation for the final accounts audit – it was noted that no further risks had been identified other than those within the External Audit Plan. This would be reviewed and an update would be provided should any issues be identified during the audit.

The Committee noted the update and good progress made to date.

NOTED

15 REVIEW OF STANDING DOCUMENTS

The Committee received a report from the Director of Finance and Performance Management which provided Members with an update on proposed changing to Standing Documentation.

Members approved the review of standing documentation and recommended their adoption to the Board at its meeting in June 2018.

APPROVED

16 REVIEW OF TERMS OF REFERENCE

Members received a report from the Director of Finance and Performance Management seeking their review and approval of the terms of reference for the Audit Committee.

Members approved the terms of reference.

APPROVED

17 ANNUAL REVIEW OF ACCOUNTING POLICIES

Members received a report from the Director of Finance and Performance Management which provided an update with regard to any changes to Accounting Policies.

The Committee reviewed and approved the Accounting Policies.

APPROVED

18 FRAUD UPDATE

Members received a report from the Director of Finance and Performance Management which provided an update on fraud allegations and notifications received from Counter Fraud Services.

Mr McNaught summarised the report for Members and highlighted the key priorities and the Committee noted the report.

NOTED

19 FRAUD ACTION PLAN

Members received a report from the Director of Finance and Performance Management which provided an update on the Board's approach to countering fraud. Mr McNaught led Members through the report and it was noted that the annual review visit from Counter Fraud Services was due to take place this month.

The Committee reviewed and noted the Fraud Action Plan.

NOTED

20 POLICY UPDATE

Members received a report from the Director of Finance and Performance Management which described progress on the updating of policies within TSH. It was noted that Clinical Effectiveness had agreed to add policies to their programme of work (from the Risk Department). This was part

of the strategy to ensure a consistent approach to the policy review process. Mr McNaught advised the Committee on the good progress to date towards the review of overdue policies, and that there would be continued close monitoring throughout 2018/19.

NOTED

21 LEVEL 2/3 RESILIENCE REPORT

The Committee received a report from the Security Director, which provided further information on data on Level 2 and Level 3 resilience incidents.

This followed presentation of the Resilience Committee Annual report to the Audit Committee in January 2018.

The Committee was content to note the update.

NOTED

22 PROJECT BANK ACCOUNTS

Members received a report from the Director of Finance and Performance Management which advised that there would be a requirement to open a Project Bank Account in respect of the Security Upgrade Project as per the Scottish Public Finance Manual.

The Committee was content to note the implementation of opening a new bank account for Projects.

NOTED

23 ANY OTHER BUSINESS

There were no further items of competent business.

NOTED

24 DATE AND TIME OF NEXT MEETING

The next meeting would take place on Thursday 28 June 2018 at 9.45am in the Boardroom, The State Hospital, Carstairs.

The meeting ended at 11.55am

NHS SCOTLAND

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	28 June 2018
Agenda Reference:	Item No: 24
Sponsoring Director:	Chief Executive
Author(s):	Chief Executive
Title of Report:	Chief Executive's Report
Purpose of Report:	For Information

1 BACKGROUND

The items noted below highlight issues in the Hospital, which do not feature on the Board's formal agenda.

2 GENERAL ISSUES OF NOTE

The Chief Executive will provide the Board with a verbal update on the following issues:

Director of Security Vacancy
Following competitive interview, Superintendent David Walker has been appointed to the post of Director of Security at the State Hospital and will be available from early December 2018. David was formerly area commander in Lanarkshire and has good working relationships with the State Hospital in his former roles.

Board Development Session 31st May 2018
A Board development session on the issue of resilience was held on the 31st of May. Information was presented on the approach to transformational change and discussion held on the broad areas of redesign. The Board identified 5 priority areas for immediate focus and action:

1) 9-5 intensive care model
2) Review of clinical care delivery model
3) Nursing resource rostering and deployment
4) Observation practice
5) Sickness / absence management

The Board will receive regular updates on progress at future meetings.

National Projects

- CEO and Medical Director participated in the National Rape Crisis Task Force on 15th May
- Planning meeting held for National FCAMHS Advisory Group held on the 17th May
- CEO and Medical Director participated in the Female Forensic Pathway meeting on the 23rd May
- CEO also attended meetings of the SMC, NEC, Forensic School Board and National Boards Meeting.
- CEO has been asked to chair the National Boards Efficiency Programme Board.

Public Health Priorities For Scotland
The Scottish Government's Health and Social Care Delivery Plan, which was published in December 2016, set out a number of specific commitments in relation to improving the health of the population. The first commitment was that the Scottish Government and COSLA would together publish a set of high level public health priorities for the wider public sector in 2018.

A paper outlining Scotland's Public Health Priorities was published as planned in June and is very much in line with the State Hospital health priorities for patients and staff. There are 6 priorities:

The six priorities:

- A Scotland where we live in vibrant, healthy and safe places and communities.
- A Scotland where we flourish in our early years.
- A Scotland where we have good mental wellbeing.
- A Scotland where we reduce the use of and harm from alcohol, tobacco and other drugs.
- A Scotland where we have a sustainable, inclusive economy with equality of outcomes for all.
- A Scotland where we eat well, have a healthy weight and are physically active.

We have endorsed these formally as a Board and will seek to ensure a clear alignment of local actions to the national outcomes.

Brexit Risk Assessment
Boards are being asked to consider and plan for the potential operational implications of EU withdrawal. Planning should include workforce and communication issues, as well as broader implications such as potential impacts on the medicines and medical equipment supply chains.

A letter will be sent to all Boards by the end of June to engage Chief Executives around the key areas of preparation and Board readiness.

Project Lift

1) Values Based Recruitment

From 1 June 2018, a consistent values based recruitment approach will be used by NHS Scotland, to fill all posts at Chief Executive, Executive Director, Director and other next level immediate direct line reports to the Chief Executive.

NHS Boards will be expected to use the guidance for all Executive Team posts, and in particular for any posts that require Cabinet Secretary approval for appointment as an executive board member, or where a member of the SG Health and Social Care Directorates is invited to be a panel member.

The 4 elements of all Executive Team appointment rounds will include psychometric testing, role play, presentation and competency based interview but there is room for flexibility around how each of these elements might be delivered.

2) Leadership Development

Project Lift has been formally launched this month. The project lift leadership development approach is all about fostering and enabling learning in practice and from practice. It is informed by the concept of "vertical development", i.e. helping you to understand and make sense of your context and to develop your capacity to think and act differently (rather than simply transferring a body of theoretical knowledge to you). The project is aimed at aspiring leaders and will aim to enable personal development in line with the national leadership framework and opportunities for personal development. The project is accessible on-line at https://www.projectlift.scot

3) Executive Performance Appraisal

From 2018/19, executive appraisal will be recorded on the TURAS system to support greater consistency of recording and application. To support this 2 national objectives have been agreed for all executive staff:

- Contribution to national priorities (e.g. H&SC Delivery Plan / Training / Research etc).
- Leadership role in NHS values and behaviours.

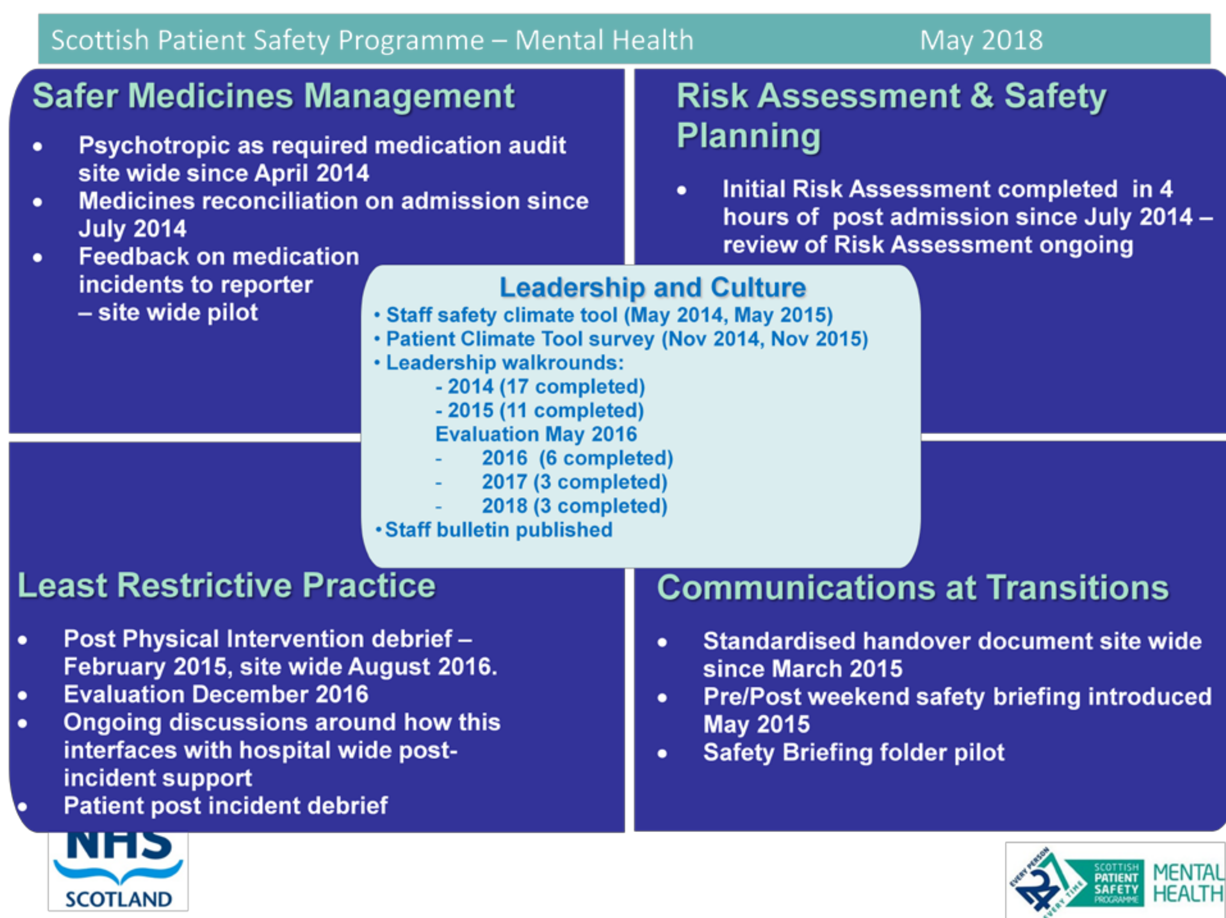
These are consistent with the local State Hospital priorities established in 2016.

3 PATIENT SAFETY UPDATE

A brief summary of SPSP activity across the Hospital in the last two months includes:

Locally, steady progress is being made across all five of the agreed national workstreams.

Work is also ongoing around Improving Observation in Practice.



Work is being co-ordinated via a multi-disciplinary steering group which is meeting regularly. Data suggests that the programme is having a positive impact on practice.

These are evidenced as follows:

- Psychotropic PRN medication documentation ('8 rights') spot check completed in May with median completion of 7.9 against the '8 rights', with two wards administering less than 10 PRN medications during the week of the spot check. August will see an electronic PRN form implemented within the hospital to capture the 8 rights information that is currently within the progress notes.

- Initial Risk Assessment completion is less than 4 hours on average.

- Medicines reconciliation completion on admission has been successful with all admissions in 2018 having a medicine reconciliation form completed.

- The SPSP oversaw the implementation of the DASA. This is now completed on every shift for all patients on enhanced observations. A short life working group is being convened to ensure clinical teams use the data to its optimum. A baseline of the EssenCES has also been carried out at and analysed across the hospital. This will be re-run next month. The EssenCES captures data in the atmosphere within the ward. This will replace the staff and patient safety climate tools.

- One of our medical members of staff has now completed the IHI fellowship and is introducing Clinical Pause within their area. This has had very positive feedback from nursing staff to date.

- A driver diagram has been started for Least Restrictive Practice and a band 7 one day a week will be recruited to take forward this piece of work.

- Three leadership walkrounds have been completed since January. Two of these have been to non clinical areas, Human Resources and Catering. Actions from all 3 have been taken forward through to Patient Safety Group.

4 HEALTHCARE ASSOCIATED INFECTION (HAI)

This is a summary of the Infection Control activity from 1st April – 30th May (unless otherwise stated)

Audit Activity:

Hand Hygiene

During this review period, there was a notable increase in the number of audits submitted towards the latter end of the quarter. Reminders to submit and follow up of non compliance will continue to be carried out by the Senior Nurse for Infection Control.

April

10 out of a possible 12 were submitted

May

11 out of a possible 12 were submitted

Table 1: % Hand Hygiene Audits Submitted April & May 2018

	April	**May**
Arran	100	100
Iona	100	100
Lewis	66	100
Mull	50	50
Health Centre	100	100
Skye	100	100

Table 2: % Hand Hygiene Compliance April & May 2018

	April	**May**
Arran	100	100
Iona	90	87.5
Lewis	90	83
Mull	70	100
Health Centre	100	100
Skye	20	60

The overall hand hygiene compliance within the hubs varies between 65-100%, Skye Centre showed a dip in April. The Senior Nurse for Infection Control and the Charge Nurse for the Skye Atrium are working to identify ways of improving compliance. Discussions are taking place with the clinical security manager to ascertain if there is any scope to relocate the dispensers. It is unlikely that this will happen until after the CAP has agreed on products.

Healthcare Waste and Workplace Inspections

The data set will is outwith the timeframe for this report.

DATIX INCIDENTS FOR INFECTION CONTROL 1st April – 30th May 2018

3 patients with symptoms of diarrhoea and / vomiting; however these were from different wards with no apparent links.

Infection control related incidents can be recorded as a secondary event following “behaviour” or “health and safety” issues. On further examination by the Senior Nurse for Infection Control there are no areas which are a cause for concern.

Scotland’s Infection Prevention and Control Education Pathway (SIPCEP) (previously Cleanliness Champions):

The SIPCEP implementation pathway was approved September 2017. This has been added to the mandatory modules and will be monitored by the Learning Development. The modules were officially launched in the hospital in November. The information provided below is for the period of November 2017 – March 2018

Core Module	**Nov 2017- March 18**
Why Infection Control Matters	301 (44.9% of target)
Breaking the Chain of Infection	362 (54% of target)
Hand hygiene	315 (new module) (47% of target)
Respiratory and Cough hygiene	308 (45.9% of target)
Role Specific Modules	
Safe disposal of waste (inc Sharps)	*165 (35.9% of target)*
PPE	*174 (38.9% of target)*
Prevention and Management of Occupational Exposure (inc Sharps)	*166 (36.1% of target)*
Blood and body fluid spillages	*201 (45.2% of target)*
Safe Management of Care Environment	*120 (30.9% of target)*
Safe Management of Care Equipment	*88 (26% of target)*
Safe Management of Linen	*120 (30.9% of target)*
Patient Placement/ Infection Risk	*92 (27.9% of target)*

Healthcare Environment Inspection (HEI):

The Standards of Dress and Clinical/Non-clinical Uniform Policy has been approved by the Senior Management Team and was launched on Monday 5th February 2018 and audit of same will be undertaken in August 2018.

Hepatitis C Treatment

There have been changes at a national level regarding for the criteria in identifying people who are suitable to receive treatment for Hepatitis C. Previously the eligibility for this depended on the individual's physical condition and progression of disease. In November 2017, the general consensus is that anyone diagnosed with hepatitis C will be eligible for treatment (unless otherwise indicated). Within the State Hospital funding for this treatment is from the patients "home" territorial board. There are currently 2 patients on treatment and 2 waiting to start treatment. It is anticipated that they will commence treatment Saturday 23rd June.

5 PATIENT ADMISSION / DISCHARGES TO 12 OCTOBER 2017

A detailed report on admissions and discharges is provided to the Clinical Governance Committee on a 6 monthly basis. The following table outlines the high level position from 17 April until 14 June 2018.

	MMI	LD	Total
Bed Complement	128	12	140
Staffed Beds (i.e. those actually available)	108	12	120
Admissions	5	0	5
Discharges / Transfers	7	0	7
Average Bed Occupancy as at 14.06 2018	-	-	104 Patients 87% of available beds 74% of all beds

8 RECOMMENDATION

The Board is invited to note the content of the Chief Executive's report.