THE STATE HOSPITALS BOARD FOR SCOTLAND

BOARD MEETING

THURSDAY 20 JUNE 2019
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 25 April February 2019	For Approval	TSH(M)19/03
4.	**Matters Arising:**		
	Actions List: Updates	For Noting	Paper No. 19/34
5.	**Chair's Report**	For Noting	Verbal
	CLINICAL GOVERNANCE		
6.	**Clinical Governance Committee – Annual Report 2018/19** Report by the Committee Chair	For Approval	Paper No. 19/35
7.	**Review of the Clinical Service Delivery Model – Update** Report by the Medical Director	For Noting	Paper No. 19/36
8.	**Health and Care Staffing – Update** Report by the Director of Nursing and AHPs	For Noting	Paper No. 19/37
9.	**Skye Centre – 12 Monthly Report** Report by the Director of Nursing and AHPs	For Noting	Paper No. 19/38
10.	**Clinical Governance Committee** Draft Minutes – 9 May 2019	For Noting	CG(M)19/02
	STAFF GOVERNANCE		
11.	**Staff Governance Committee – Annual Report 2018/19** Report by the Committee Chair	For Approval	Paper No. 19/39
12.	**Remuneration Committee – Annual Report 2018/19** Report by the Committee Chair	For Approval	Paper No. 19/40
13.	**Response to Report to the Cabinet Secretary for Health and**	For	Verbal

	Sport – Cultural Issues related to allegations of Bullying and Harassment in NHS Highland Report by the Interim Director of HR	Discussion	
14.	**Attendance Management – Board Update** Report by the Interim Director of HR	For Noting	Paper No. 19/41
15.	**Staff Governance Committee** Chair's Report – 23 May 2019	For Noting	Verbal

CORPORATE GOVERNANCE

16.	**Audit Committee – Annual Report 2018/19** Report by the Committee Chair	For Approval	Paper No. 19/42
17.	**Annual Accounts for year ended 31 March 2019** Report by the Director of Finance & Performance Management	For Approval	Paper No. 19/43
18.	**Finance Report to 31 May 2019** Report by the Director of Finance & Performance Management	For Noting	Paper No. 19/44
19.	**Annual Review of Standing Documentation** Report by the Director of Finance & Performance Management	For Approval	Paper No. 19/45
20.	**Property and Asset Management Strategy** Report by the Director of Security, Estates and Facilities	For Approval	Paper No. 19/46
21.	**Performance Report 2018/19** Report by the Director of Finance & Performance Management	For Noting	Paper No. 19/47
22.	**Corporate Governance – Improvement Plan Update** Report by the Board Secretary	For Noting	Paper No. 19/48
23.	**Audit Committee** Draft Minutes – 28 March 2019	For Noting	A(M)19/02
24.	**Chief Executive's Report**	For Noting	Paper No. 19/49
25.	**Any Other Business**		
26.	**Date and Time of next meeting** 22 August 2019, 1pm 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.

THE STATE HOSPITALS BOARD FOR SCOTLAND ***TSH(M)19/03***

Minutes of the meeting of The State Hospitals Board for Scotland held on Thursday 25 April 2019 at 9.45am in the Boardroom, The State Hospital, Carstairs.

Chaired by Non-Executive Director: Bill Brackenridge

Present:

Employee Director	Tom Hair
Chief Executive	Gary Jenkins
Non Executive Director	Nicholas Johnston
Non Executive Director	David McConnell
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:

Acting Social Work Manager	Peter Di Mascio
Head of Communications	Caroline McCarron
Head of Corporate Planning and Business Support	Monica Merson
Interim Human Resources Director	Kay Sandilands
Consultant Forensic Psychiatrist	Gordon Skilling [Item 6]
Board Secretary	Margaret Smith
Patient Centred Improvement Advisor	Leanne Tennant [Item 6]
Director of Security, Estates and Facilities	David Walker

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

Mr Brackenridge welcomed everyone to the meeting, and confirmed Members' agreement to his chairing of the session in the absence of Board Chair, Mr Terry Currie, who had offered his apologies.

Mr Brackenridge welcomed Mr Jenkins to the meeting in his new role as Chief Executive, and Mr Hair in his new role as Employee Director.

NOTED

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.

NOTED

3 MINUTES OF THE PREVIOUS MEETING

The Minutes of the previous meeting held on 28 February 2019 were noted to be an accurate record of the meeting.

APPROVED

4 ACTION POINTS AND MATTERS ARISING FROM PREVIOUS MEETING

The Board noted progress on the action points from the last meeting - each action was completed or on today's agenda.

NOTED

5 CHAIR'S REPORT

Mr Brackenridge provided Members with an update from the Board Chair Mr Currie following the NHSScotland Board Chairs meeting which had taken place on 25 March 2019.

The Cabinet Secretary had spoken of the importance of the work currently being undertaken around Corporate Governance. The Action Plans were due to be completed and submitted by the end of April 2019.

The Cabinet Secretary referred to concerns around Infection Prevention and Control. She sought assurances that every Chair had read the Queen Elizabeth Hospital Inspection Report. In particular she was concerned with unfilled posts for cleaning staff and the frequency of reviews to ensure that maintenance schedules were being implemented within the due timescales.

The Cabinet Secretary had also referred to the Health and Care Staffing Bill and highlighted key amendments from Government to the draft bill. She had highlighted her concerns around A&E waiting times.

The Minister for Mental Health had delivered a paper ''Better Mental Health in Scotland'' – the programme of reform to improve support for mental health. There were five strands of work: Reforming children and young people's mental health, Improving specialist services for young people and adults, Taking a 21st century approach to adult mental health, Respecting, protecting and fulfilling rights, Making suicide prevention everyone's business.

Under taking a 21st century approach to adult mental health, the Minister referred to the review of forensic mental health services. In particular, she noted key developments such as the decline in number of patients detained in high security, the changes in medium secure services, the introduction of excessive security appeals for patients detained in medium security and a continuing move towards community services. There is now a need to review more widely the delivery of mental health services in light of these changes and new developments. Future forensic mental health services should reflect the proposed future structures of forensic services, key priorities for our health services and joined up practices with criminal justice services. The Cabinet Secretary had asked Chairs to look at processes for responding.

NOTED

6 PATIENT, CARER AND VOLUNTEER STORIES - A CARER STORY

Dr Skilling and Ms Tennant were in attendance at the meeting to present a carer's story to the Board. Dr Skilling introduced this through reference to the programme of work led by the Chief Medical Officer on Realistic Medicine in NHS Scotland and in particular the focus on personalising realistic medicine so that patients are listened to and have input to their care pathway.

The Board then heard a recording made by a carer of a former patient of The State Hospital (TSH)

which focussed on her preconceptions of hospital before first coming here to visit her father, some detail about his care pathway whist being cared for here and the changes that she experienced as a carer. Ms Tennant demonstrated the emotional touchpoints on a slide presentation as the recording was played.

The carer's story told of how, initially, she had felt great fear of the hospital itself and had been rather bewildered when approaching the entrance and becoming aware of the physical security in place. However, the personal contact she received from the moment when she was greeted at reception, seeing the community feeling and facilities on site as well as the warm welcome from staff had relieved her fears greatly.

TSH was not what she had expected and she had many good experiences at the hospital with her father. She credited the hospital and its staff for the care delivered to her father. She wished to highlight how essential it was that, as a carer, she never felt that staff were judging her or her father and had approached them both not only with respect but also affection. She had felt that this represented compassionate care and was a benchmark for how care should be delivered to patients in a high secure setting.

Board Members recognised the powerful nature of this story, especially the power of small things. It had meant a lot to this lady that she had been met at reception and that during her visit in the hub staff were on hand to make her a cup of tea. Members reflected on how these small touches were representative of the values of the organisation. Further, that this story ably demonstrated the dedication and skill of staff especially through the way in which this lady's preconceptions had changed from the moment when she first arrived at the hospital. The Board sought assurance that this story would be cascaded to staff as an important piece of feedback, and Mr Richards confirmed that this would be taken forward.

Action - Mr Richards

NOTED

7 REVIEW OF THE CLINICAL MODEL - UPDATE

The Board received a report from the Medical Director to provide an update on the review of the clinical model, and Professor Thomson led Members through the detail of the work progressed since the last Board meeting on 28 February 2019. Following the workshops held with staff, patients and stakeholders held in February, there had been a focus on staff engagement and the report reflected on the feedback received to date.

Professor Thomson provided an update to the paper, explaining that the workshop schedule for May 2019 would seek agreement on the benefits criteria of the options presented. This would allow additional scope to focus on how to deliver the model including financial and workforce planning. A formal options appraisal workshop would then follow on the three models.

Mr Jenkins emphasised that it was essential for the model to be realistic and credible and also that any workforce changes would be taken forward in partnership with staff.

Members considered and agreed to this process focussing on the need to consider any resource implications as well as the framework for implementation of the agreed model. They reflected on the need to manage expectations throughout the process. Members sought assurance that feedback was being provided to staff on how this was process was developing and Professor Thomson outlined both the communications process underway with staff as well as the focus on wide engagement with staff groups directly. The aim for the workshop taking place in May would be to weight the benefits and would include a wide range of staff.

The Board also considered the impact of any change to the delivery of care may have on culture within the hospital - any change must be taken forward with staff. Mr Jenkins referred to a number

of sub-themes that had emerged through the course of the process so far. It was essential to differentiate between the delivery of the clinical model, focussed on the patient care pathway, and wider emergent cultural themes that would require a specific focus. He also emphasised the need for a refreshed recruitment strategy in the context of the delivery of the clinical model as well as safe staffing legislation Mr Richards added assurance for the Board on the work currently progressed through engagement with universities to attract newly graduating nurses to a career at TSH.

It was agreed that a further update on progress would be brought back to the Board at its next meeting in June 2019.

Action - Professor Thomson

NOTED

8 CLINICAL GOVERNANCE COMMITTEE – CHAIR'S REPORT

The Board received the draft minutes of the meeting of the Clinical Governance Committee which took place on the 14 February 2019.

The Committee Chair, Mr Johnston, highlighted the update received from the Mental Health Practice Steering Group, and that there had been a discussion item on suicide prevention. The timescale for reporting of Category 1 and 2 risk reviews had been discussed in detail and the Committee had requested that further detail be reported back to the Committee at its next meeting.

NOTED

9 ATTENDANCE MANAGEMENT IMPROVEMENT TASK GROUP

A verbal report was received from The Interim Human Resources Director to update the Board on the work of the Attendance Management Improvement Task Group (AMITG). Having taken forward the action plan as reported to the Board at its last meeting, the group had paused to undertake a re-fresh of its approach. The Group would meet in May 2019 to consider its future direction of travel. There had been a recent improvement in sickness absence rates for the Board although at the same it was acknowledged that continued and sustained improvement was required. Ms Sandilands also highlighted the implementation of the new national policies across NHS Scotland this year, and the expectation nationally that Boards should reduce sickness absence by 0.5% each year.

Members welcomed feedback of a noticed change within the organisation of impact through increased HR support. Ms Sandilands noted that external indicators such as internal audit had demonstrated an improved position, but that there was still further improvement to be made within the HR department.

The Board asked if any further work could be undertaken particularly exploration of initiatives undertaken at other NHS Scotland, and Ms Sandilands confirmed that this would form part of the work taken forward by the re-freshed AMIWG. Mr Jenkins underlined the view that it would be helpful to pause and reflect on the measures that had been most effective to date based on the evidence, and then exploring the opportunities for change in the context of the overall culture and values within the organisation.

The Board asked for an update to come to each Board meeting in the future, tracking absence levels, given the importance of this issue to the organisation overall.

Action - Ms Sandilands

NOTED

10 STAFF GOVERNANCE COMMITTEE

The Board noted the draft minutes of the Staff Governance Committee meeting held on 7 February 2019. The Committee Chair, Mr Brackenridge the key issues considered at the meeting, particularly attendance management and policy compliance within Human Resources as well as the Occupational Health (OH) service. It was noted that further reports had been requested on the EASY service and the metrics for measuring impacts for the OH service.

NOTED

11 FINANCE REPORT AS AT 31 MARCH 2019

The draft Finance Report to 31 March 2019 was submitted to the Board by the Director of Finance and Performance Management. Mr McNaught that end of year adjustments were ongoing and that the final position for 2018/19 was expected to be break-even. External audit would take place in May 2019. Mr McNaught highlighted pressures in the coming financial year particularly on the nursing budget as well as a challenging position for unidentified savings.

The Board discussed the presentation of the paper with particular reference to the transparency of the granularity of detail and agreed to a need for greater narrative and context around the control process. This should offer more transparency of the information and highlight the magnitude and likelihood of any particular financial pressures.

Action – Mr McNaught

There was discussion on the challenges facing the Board in the current year, especially the balance of recurring to non-recurring savings, and the need to improve the position on recurring savings. The Board noted the need to reduce spending on overtime payment within nursing through cohesive workforce planning. Mr Jenkins noted concern that the Board's position on overtime did not compare well with the position of other NHS Scotland Boards and that this was a key priority for the Board in the coming year.

The three year planning cycle was considered by the Board, and the possible challenge of any overspend in year one then being retrieved through savings on the following years of the cycle as compared to a balanced budget in each year. At the same it was noted that this could present opportunities to invest to save and plan spending over the course of the three year cycle provided this was done in a controlled way.

NOTED

12 DRAFT OPERATIONAL PLAN

The Board received a report from the Director of Finance and Performance Management to submit the draft Annual Operational Plan for approval as well as to invite discussion and feedback.

Mr Jenkins emphasised the need to place TSH as an equal partner within the context of NHS Scotland, and taking forward this approach on a number of levels as outlined in the plan. At the same time, the Board's unique position within NHS Scotland was noted and that the operational plan should reflect that position. He offered the Board assurance that plan would be taken forward by way of partnership working with staff.

The Board agreed that any further comment or revision should be submitted to Mr Jenkins within one week to allow submission to Scottish Government and that a further update would be brought back to the June meeting of the Board.

Action - Mr Jenkins

AGREED

13 CORPORATE GOVERNANCE BLUEPRINT

Mr Brackenridge introduced this report, which followed the Board's self-assessment and Development Session undertaken as part of implementation of the Corporate Governance Blueprint. The report included the Board's Improvement Plan to be taken forward in the coming year.

Members agreed that the report and associated plan set out the key findings of the self-assessment as well as the key priorities for the Board over the coming year. Members discussed the need to be realistic in setting targets to ensure that the Board could deliver on each. The timescales set for delivery should be realistic. At the same time there was reassurance that some key pieces of work were noted to already be underway.

There was discussion on how to define culture within TSH to define the strengths and weaknesses across the organisation.

The Board reflected on the positive way in which the process of undertaking the self -assessment and development session had engendered full and valuable discussion of the key corporate governance priorities of the Board.

The Board approved the report and improvement plan to Scottish Government, subject to minor revision. An update on the implementation of the Improvement Plan would be added as a standing Item to each Board meeting.

Action – Ms Smith

APPROVED

14 ANNUAL REVIEW OF STANDING DOCUMENTATION

The Board received a report from the Director of Finance and Performance Management seeking approval of Standing Documentation, with no proposed amendment.

Members reviewed and discussed, noting the need to re-fresh the wording in relation to key personnel. In particular, the Standing Orders should reflect the Board's position should the Chair not be available to preside over a Board meeting. The position in terms of the Common Seal of the Board should also be verified.

It was noted that the Standing Documentation as a whole should be re-submitted to the June Board Meeting for final approval. This would be done by way of addendum to the existing papers to reflect any changes.

Action Mr McNaught/ Ms Smith

NOTED

15 AUDIT COMMITTEE

The Board noted the approved minutes of the Audit Committee which took place on 24 January 2019.

The Chair of the Committee, Mr McConnell provided a verbal update of the meeting which had taken place on 28 March 2019 and had focussed substantially on the year end financial position as well as the internal auditor's final report for 21018/19 and workplan for internal audit for 2019/20.

NOTED

16 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.

Mr Jenkins reflected on his initial weeks in his role as Chief Executive and provided a report to the Board on his activities to date. He spoke of on how TSH positioned itself within NHS Scotland and how to strengthen its profile in this context. He had also chaired his first meetings of the Senior Management Team as well as the Partnership Forum.

He had attended the National Board Collaborative Programme Board as well as the National Chief Executives Meetings. He had also focussed on links with Scottish Government colleagues within the Mental Health Directorate (MHD) and would be seeking to build on these - with a visit to the MHD scheduled for early June. Similarly, he had engaged with the Director General of NHS Scotland, seeking to take TSH forward as a forward thinking Board within NHS Scotland. He had also established links for TSH with his counterpart in NSS and a visit to TSH was being arranged.

Within the organisation, Me Jenkins had toured the estate and had visited ward areas as well as the Skye Centre meeting patients and staff to help him become more familiar with the unique challenges of a high secure environment.

Mr Jenkins asked the Board to note the summary contained within his report relating to patient safety, infection control and bed numbers. In relation to infection control, Mr Richards confirmed that following the Healthcare Environment Inspectorate report into the Queen Elizabeth University Hospital, TSH had reviewed its own practice and no issues of concern had been reported. The required reporting had been submitted to Scottish Government to confirm that this was the case.

Members were content to note this report.

NOTED

17 ANY OTHER BUSINESS

There were no other items of competent business for discussion at this meeting.

NOTED

18 DATE AND TIME OF NEXT MEETING

The next meeting would take place on Thursday 20 June 2019 at 1pm in the Boardroom, The State Hospital, Carstairs.

NOTED

19 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.

AGREED

ADOPTED BY THE BOARD

CHAIR _____
(Signed Mr Terry Currie)

DATE 25 April 2019

MINUTE ACTION POINTS
THE STATE HOSPITALS BOARD FOR SCOTLAND
(From April 2019)

ACTION NO	AGENDA ITEM NO	ITEM	ACTION POINT	LEAD	TIMESCALE	STATUS
1	6	A Carer Story	Story to be cascaded to staff for awareness. Update - feedback offered directly to the wider staff group in Mull on back of Board meeting, and also shared through the nursing and AHP advisory committee structure for cascade.	Mr Richards	June 2019	**Completed**
2	7	Review of Clinical Model	A further update to June meeting	Lindsay Thomson	June 2019	**On Agenda**
3	19	Attendance Management Improvement Task Group	Standing item on each Board agenda.	Kay Sandilands	June 2019	**On Board Agenda as standing Item**
4	11	Finance Report as at 31 March 2019	Review presentation of report.	Mr McNaught	June 2019	**On Agenda**
5	12	Draft Annual Operational Plan	Update to be brought back to the Board	Me Jenkins	June 2019	**On Agenda**
6	13	Corporate Governance Blueprint	Update on Improvement Plan as standing item.	Ms Smith	June 2019	**On Agenda**

7	14	Annual Review of Standing Documentation	To be re-submitted for final approval – by of addendum signifying any changes	Mr McNaught	June 2019	**On Agenda**

Paper No. 19/35

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	20 June 2019
Agenda Reference:	Item 6
Sponsoring Director:	Medical Director
Author(s):	Medical Director/Clinical Effectiveness Team Leader
Title of Report:	Clinical Governance Annual Stock Take
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 2018/19. 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 Committee is asked to approve the Governance Reporting Arrangements, Terms of Reference, Programme of Work and the Clinical Governance Committee Annual Report.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives?	As outlined within report
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
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	None identified
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One √ There are no privacy implications. □ There are privacy implications, but full DPIA not needed □ There are privacy implications , full DPIA included.

Date Report Prepared:	12TH April 2019
Prepared by:	Clinical Effectiveness Team Leader

THE STATE HOSPITALS BOARD FOR SCOTLAND

CLINICAL GOVERNANCE COMMITTEE ANNUAL REPORT

1 April 2018 – 31 March 2019

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 3 main quality ambitions:

1. 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.
2. 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.
3. 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 2017/18 and examples of good practice and matters of concern

2. Committee Chair, Committee Members and Attendees

Committee Chair
Nicholas Johnston, Non-Executive Director

Committee Members
Maire Whitehead, Non-Executive Director
Elizabeth Carmichael, Non-Executive Director (until November 2018)
David McConnell (from December 2018)

Attendees
Terry Curry, NHS Board Chair
James Crichton, Chief Executive
Prof. Lindsay Thomson, Medical Director
Gary MacPherson, Interim Head of Psychology (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
Sheila Smith, Clinical Effectiveness Team Leader

3. Meetings during 2018/19

During 2018/19 the Clinical Governance Committee met on 4 occasions, in line with its terms of reference. Meetings were held on:

- 10 May 2018
- 9 August 2018
- 8 November 2018
- 14 February 2019

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

Child and Adult Protection
The Committee received and noted the report in May and it covered the period 1 April 2017 - 31 March 2018. The report highlighted key areas of work that included the approval of an updated child protection summary and child contact assessment/ review templates that had been implemented with the relevant sections of the CPA document being updated; the introduction of a new patient factsheet in relation to Adult Protection had been developed and available to patients' for their information; Corporate Parenting Plan slides are now included within the Child Protection Induction training and improvements were made to the ASP AP1 Referral and DATIX system.

Fitness to Practice
The Committee received a report in relation to Fitness to Practise at its May meeting. The reporting period covered was 1 April 2017 - 31 March 2018. The report was submitted to the Committee for information in respect of the process for monitoring professional registration status at The State Hospital thus providing assurance that all relevant staff hold current professional registration as appropriate. 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.

Infection Control
At the May meeting, the Committee noted the progress in the Infection Control Annual Report 2017/18 (covering 1 April 2017 - 31 March 2018) and endorsed the Programme of Work for 2018 - 19. The report outlined the wide range of Infection Control activity undertaken within the Hospital and summarised the work conducted within the Infection Control Services. Key achievements over the year included a full uniform review and publication of a revised Standards of Dress and Clinical/Non-clinical Uniform Policy as a result of the HEI recommendation regarding the wearing of wrist watches; review of the procuring of patient equipment; review / audit of patient carry out meals; water safety

group review of the risk assessment; development of acute boarding out leave (ABOL) protocol and the incorporation of BBV testing into admission blood screening.

Research Committee/Research Governance and Funding
In May the Committee received and approved the 2017/18 Research Committee Annual Report. The reporting period covered was 1 April 2017 - 31 March 2018. The main areas of focus were the range of research activity and its dissemination undertaken by State Hospital staff over the period of 2017/18, the annual Research and Clinical Effectiveness conference, and the Forensic Network Research conference. The report also provided additional approaches to monitoring performance by taking aspects of the Research Strategy 2016 - 2020, as requested by the Clinical Governance Committee, and utilising these within the annual report as a means of monitoring and reporting upon the progress made.

Corporate Risk Register
The Committee received and noted a report on progress with the Corporate Risk Register at its August meeting. The report highlighted that the Corporate Risk Register is currently being reviewed by internal audit. A new group within the hospital is being set up to oversee the review of the corporate risks. The group will be called the Risk, Finance and Performance Group. Draft terms of reference were being drawn up at the time of the report. The report included information on the departments that hold local risk registers and the owners of these.

CPA/MAPPA
At the August meeting the Committee noted the report covering the period 1 July 2017 - 30 June 2018 and supported the future areas of work. 97% of transfers were managed through the CPA process. 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. During the reporting year the vacant CPA Administrator post was reviewed. In light of the consistently lower number of patients the post was not filled. A contingency plan has been agreed with the clinical secretary coordinator to provide CPA administrative support in the absence of the Social Work PA/Administrator, as required.

Patient Safety
In August the Committee received and approved the Patient Safety Report covering the period 1 July 2017 - 30 June 2018. 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, i.e. Leadership and Culture; Communication at Transitions; Safer Medicines Management; Violence, Restraint and Seclusion Reduction; and Risk Assessment and Planning. A range of areas within the report was discussed by the Committee members in relation to the programme of Leadership Walkrounds emphasising the need to ensure commitment to these; the introduction of EssenCES, Clinical Pause and DASA and the trends in observation practice and the staffing associated with this.

Forensic Network Medium and High Secure Care Review Visit Report
At the November meeting the report that included the findings from the April visit was noted. The report looked at the 6 themes: Assessment, care planning and treatment; Physical health; Risk (including assessment, detention, compulsion and patient safety); Management and Prevention of Violence; Physical Environment; Teams, Skills and Staffing. The Committee noted the report and approved the process for monitoring the action plan that had been agreed.

Medicines Committee
In November the Committee received and noted information on the key pieces of work undertaken throughout the year (1 October 2017 - 30 September 2018) 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 several policy/guidance updates, a significant clinical audit work programme, support for an independent prescriber framework in chronic physical health conditions, ensuring safe administration of a number of specialist medicines and a recommendation to convene a more timely and thorough medication incident review group. Core ongoing medicines management work on expenditure and formulary usage remains in place with positive results. The report noted that in the coming year, as well as the regular work plan, there will be work undertaken around medicine supply challenges, electronic prescribing advances and Scottish Government prescribing indicators.

Physical Health Steering Group
In November the Committee received and noted the 12 month rolling report from the Physical Health Steering covering the period 1 October 2017 - 30 September 2018. The report noted the developments and progress made in the 5 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 performance management targets.

Rehabilitation Therapies Service
In November the Committee approved the report and endorsed the future areas of work and service developments contained within it. The report provided a summary of the key areas of work that included the Allied Health Professionals use of the Skye Centre Woodwork room; the Arran Hub Occupational Therapist engaging with national dementia programme on connecting people, connecting support and securing a place on the Tailored Activity Programme (TAP). The Occupational Therapist on Lewis Hub supported evening hub opening with MDT members to enable social and recreational activity off ward in the evening. All Occupational Therapy staff participated in an appreciative inquiry event in January, which is based on service improvement methodology to plan service developments.

Members congratulated the Lead AHP on the impact she had made during her first year in post. The improvement in data and honest appraisal of progress to date was welcomed.

Safety Report Action Plan
At the November meeting the Committee noted the action plan that was agreed as a result of the Safety Report. The report examined the issue of safety by considering the responses to the Staff Survey and the data over a five year period, where available, on incidents including assaults, attempted assaults and disturbed behaviour; observation levels; reporting of injuries, diseases and dangerous occurrences (RIDDORS); and use of seclusion for the whole State Hospital population. Data was further analysed by primary diagnosis of major mental illness or intellectual disability, and by admission or rehabilitation stage of progress. An action plan was agreed from the recommendations within the report. An update from the action plan was tabled at the February meeting.

Clinical Governance Group
At the February meeting the Committee received and noted the second 12 monthly report from the Clinical Governance Group covering the period 1 January 2018 - 31 December 2018. 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: ensuring that the supporting healthy

choices workstream is progressing with work on all 15 recommendations being taken forward in a timely manner; the clinical outcome measures data that is reported quarterly allows the clinical teams to have fuller discussions with regards to improvements that could be made in the patients care pathway; the group ensures that all new guidelines published that are relevant to the patients within The State Hospital are reviewed, ensuring we are providing the most up to date evidence based care possible; ensuring that the patients day project is being progressed and assisting in agreeing the option that should be progressed to take the project to the next stage and ensuring delivery of the staff and patient safety action plan.

Forensic Medium and High Secure Care Standards – Action Plan Update
In February the Committee received the first draft of the action plan resulting from the visit in April 2018. There were 11 high graded actions, 15 medium graded actions and 11 low graded actions. The Committee requested that one of the low graded actions relating to visits within the hospital be given a high grade as the hospital has been getting feedback from carers for a number of years around the time taken to reach the wards. The Committee also asked that the action plan is tabled at the Committee 6 monthly with 2 monthly reports going to the Clinical Governance Group to ensure a timely delivery of the action plan.

Mental Health Practice Steering Group
A report was submitted to the February meeting covering the period 1 January - 31 October 2018. The key pieces of work from the group included: reviewing and monitoring of published mental health standards and guidelines; monitoring of psychological services data; monitoring risk assessment completion; relational approaches to care; trauma informed care and monitoring of the mental health interventions from the Variance Analysis Tool. Future areas of work included: making CPAs meaningful for patients and carers and ensuring that Advance Statements are balanced, proportionate, and realistic.

Psychological Therapies
At the February meeting the Committee noted the Psychological Services report covering the period 1 January 2018 - 31 December 2018. The report was centred on the 6 quality dimensions from The Healthcare Quality Strategy for NHS Scotland. Key service developments during 2018 included: changes to group work to make content more trauma informed; delivering healthy living (weight loss) and diabetic intervention groups; QI project supported by NHS Quality improvement Scotland to increase group therapy productivity and efficiencies; leadership and major contribution to TSH 3030 projects; on-going strong links with national and international academic and doctoral trainee psychologists programmes. A new structured formulation guide and audit of formulation quality has been agreed and is in progress; pilot of new neuropsychological testing is underway and a new assessment template that focuses on Adverse Childhood Experiences, Attachment, neurodevelopment and traumatic brain injury is undergoing proof of concept implementation. The service is heavily involved in local and national strategic groups and promulgates forensic and scientific knowledge via local, national and international presentations and publications.

4.2 Standing Items Considered by the Committee during the Year

Duty of Candour
Duty of Candour, part of the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016 came into effect on 1 April 2018. It was agreed that Duty of Candour would be a standing agenda item for the first year. A quarterly report was submitted to each meeting highlighting various areas of work that included:

- Updates on the Duty of Candour Policy that is now at draft stage. This policy provides detail of the governance and processes in place to support Duty of Candour implementation.

- The number of incidents identified since April 2018 that meet the requirement of Duty of Candour. This was consistently zero throughout the year.
- The number of Datix incidents reviewed with a consequence/impact of moderate or greater which meet the Duty of Candour requirements which have been reviewed by the Duty of Candour core group as between 0 and 2

During the first year there were 3 cases where consideration was given to the potential of the application of Duty of Candour. These were discussed within the Duty of Candour core group. It was agreed that Duty of Candour did not apply however it was identified that value was gained by discussing the cases in detail, particularly in relation to ASP. An annual report will be submitted to the May 2019 meeting, with the reporting schedule changing from quarterly to annual at this point.

Category 1 Reviews
Three Category 1 Review reports were considered during the reporting year. All had their recommendations and actions agreed. There were concerns noted over the length of time it is taking to complete the Category 1 Review process. Further work will be undertaken during 2019 to review the Category 1 Review process.

Learning from Complaints and Feedback Report
The quarterly Learning from Complaints and Feedback report was considered and noted at the Clinical Governance Committee at every meeting. The reports highlight the feedback received, encompassing complaints, concerns, comments and suggestions and any compliments/positive feedback received. Actions arising from all types of feedback are included within the report to share the learning which enables the organisation to develop services which take cognisance of stakeholder feedback. The report is based on the new two stage model that enables complaints to be handled either locally, by front line staff, allowing for *Early Resolution* (Stage 1) within 5 working days, or for issues that cannot be resolved quickly or are more complex, by *Investigation* (Stage 2) within 20 working days. This has been fully implemented across the hospital and forms the basis for the quarterly reports. All responses that have been received through the Complaints Experience Feedback Forms from patients/carers are also included within the reports.

Patient Movement Statistical Information
The Committee received and noted 2 reports during the year at its May and November meetings. The May report covered the reporting period 1 September 2017 - 31 March 2018 and the November report covered 1 April 2018 - 30 September 2018. 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 2017/18 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 was discussed at the November 2018 meeting.

Physical Activity
The Chair of the Physical Health Steering Group presented on physical activity. He highlighted key areas of work notably the development of health and well-being plans for each patient, using a national screening tool. This had been piloted within Arran 1. He explained the mechanism behind this for the patient from the point of admission and through their care journey using the PDSA model - plan, do, study, act.

It was hoped that this process could be taken forward via RiO, would provide data for audit on areas such as BMI, activity and shop purchases. It would be challenging to bring this together, particularly given the different areas being considered. However, this would bring greater convergence and accountability in reviewing patient needs. At the same time, it was recognised that it may be challenging to provide sufficient staff resourcing in support. The Committee emphasised that this was a key clinical priority for the hospital and health and well-being plans should be considered a key importance. There were complex ethical issues to be considered in implementing these for both clinicians and the Board.

Suicide Prevention and Self Harm
At the May meeting, due to time constraints, this item was deferred to August. Due to staff resource issues at the August meeting the item was deferred to February 2019. A presentation was given to the February meeting that gave an overview to the Committee of the 4 year delivery plan from the National Suicide Leadership Group. The target for the delivery plan is to reduce suicide rates by 20% by 2022. There are 10 actions associated with the delivery plan. These are:

- Local prevention action plans
- Suicide prevention training
- Public awareness
- Support for those affected by suicide
- Crisis support
- Digital Technology
- At risk groups
- Children and young people
- Data, evidence and improvement
- Reviews

The Committee noted the presentation.

6. Special Topics/Items for Approval

Clinical Governance Annual Stock Take
At its May meeting, the Committee received and noted: the Clinical Governance Reporting Structures for 2018-19; the Programme of Work for 2018-19 subsequent to any changes that may arise at future meetings; the Clinical Governance Committee Terms of Reference; and the Clinical Governance Annual Report 2017-2018. The annual report summarised the work of the Committee during the financial year 1 April 2017 - 31 March 2018.

Patient Day Project
The Committee received an update in February detailing the work of the Patient Day Project Group since its re-establishment in October 2018. The group has revisited their

Terms of Reference and the objectives/aims of the group in relation to the Patient Active Day Model. By December 2018 it was agreed that the Patient Day model would be implemented across the remaining 2 hubs (Mull and Iona) and Arran 2 session times would be reviewed to increase this back to 2 sessions as of January 2019. Information in relation to the model was disseminated to ward staff, members of the wider clinical team, and patients. The extended project was implemented the week commencing 7 January 2019 across all 4 hubs. For Arran 2, the model had been running for 4 months prior to the format being reviewed in December 2018. Arran 2 initially attended 2 sessions each week. Achieving ward closure, as a key facet of the model, has been achieved on every occasion with those patients unable to participate in Skye Centre activities being re-located into Arran 1. No data was available at the time of the February meeting on the impact of extending the project to Mull and Iona although, going forward, this integrated active day approach will be a central plank of any service changes agreed through the review of the clinical care delivery model that is currently underway.

Internal Audit Report on Physical Activity
At its August meeting the internal audit report was tabled under any other business. The report had originally been tabled at the Audit Committee with a view that it should come to the Clinical Governance Committee for clinical consideration of the recommendations. The main areas discussed were: requirement to improve the way the hospital captures patient activity; the state of play with the Patient Day Model; the need to implement the Health & Wellbeing Plans and the need to review the Clinical Model. All these areas were included within the Committees plan of work.

7. Areas of Good Practice Identified by the Committee

Infection Control & Patient Safety Report
The implementation of the Acute Board Out Laptop (ABOL) that allows comprehensive shift reports and DASAs to be sent back to the hospital when a patient is boarding out at a general hospital due to problems with their physical health.

CPA/MAPPA Report
The continued work to engage carers with the discharge CPA process and carers in general through the Carers Day Event.

Rehabilitation Therapies Report
Vignettes within the Rehabilitation Therapies Service report and the improvement in data available.

Safety Report Action Plan
The timely manner in which some of the actions within the Staff and Patient Safety Report were delivered.

Duty of Candour
The successful implementation of the Duty of Candour legislation within the hospital, with robust processes in place to monitor adherence.

8. Matters of Concern to the Committee

Matters of Concern	Update
Compliance rates with completion of on-line modules has been noted as a concern. It was agreed that this was an area of concern for the Committee and should be tracked to monitor improvement.	A paper has been provided to the November meeting showing the compliance rates with completion of on line modules.
The impact of staff absence on filling shifts and patient activity within the hospital.	An absence task group was established in August 2018 with an objective to reduce absence by 3% by March 2019. A range of measures are being taken to improve attendance at work and absence in August reduced by 1.63% to 8.27% overall. A cap of 23hrs additional per week is being more rigorously enforced to ensure that staff are not working excessive and unsafe numbers of hrs. While this may have an additional pressure in terms of unfilled shifts, 10 new staff have been recruited to the Nurse Pool which should assist in reducing this trend.
The time taken to complete Category 1 and Category 2 reviews	Verbal update given at February meeting. Further paper to be tabled at May 2019 meeting as Committee still has concerns.
The increase in 'staff resources' within the incidents report and the impact of this on patient care	The Attendance Management Group has been re-constituted and activity data has also been provided to the Committee. There is still work required with this in relation to sickness absence.

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.

The State Hospital

CLINICAL GOVERNANCE COMMITTEE

TERMS OF REFERENCE

1 PURPOSE

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

2 COMPOSITION

2.1 Membership

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

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

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

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)
- D McConnell

Ex-officio Members

- Terry Currie, Chairperson

In Attendance

- Gary Jenkins, Chief Executive
- Prof. Lindsay Thomson, Medical Director
- John Marshall, 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 approval by the Committee and notification to the Board.

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

4 REMIT

4.1 Objectives

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

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

4.2 Systems and Accountability

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

4.3 Safe and Effective Care

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

- Structures are in place to minimise potential problems such as effective risk assessment and management, incident reporting, critical incident reviews, and complaint procedures
- Lessons are being learned from adverse events and near misses
- 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 Person Centred Improvement activities, including equality and diversity issues pertinent to clinical governance.
- To ensure that care is provided by appropriately trained and skilled professionals with the competencies required to deliver the required care.
- To ensure that clinical policies and procedures are developed, implemented and reviewed.
- To ensure that poor performance of clinical care will be identified and remedial action taken.

4.5 Control Assurance

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

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

5 AUTHORITY

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

6 PERFORMANCE OF THE COMMITTEE

The Committee shall annually review and report on:

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

7 REPORTING FORMAT AND FREQUENCY

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

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

8 COMMUNICATION AND LINKS

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

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

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

Subject to annual review.
Next revision: May 2020.

Paper No: 19/36

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	20 June 19
Agenda Reference:	Item No: 7
Sponsoring Director:	Medical Director
Author(s):	Head of Corporate Planning and Business Support
Title of Report:	Review of Clinical Model
Purpose of Report:	For noting

1 SITUATION

This report provides and update to The Board on a review and consultation on The Clinical Model. The consultation on the Clinical Model arose from a presentation to the Board on 28th June 2018 by the Service Transformation and Sustainability Group where comments were expressed by staff on the current structure for the delivery of care.

2 BACKGROUND

The clinical care model describes the way The State Hospital provides high secure services to patients with a mental disorder many of whom have offended. The need to review the Clinical Care Model arose from issues raised through a staff engagement exercise which focused on readiness to change. As part of the Service Transformation and Sustainability projects, this stream of work has focused on the review of the clinical care model. This work is split into three parts:

1. Review of the clinical model principles
2. Review of safety factors
3. Review of the clinical service delivery model.

The Board received an update in October 2018 on point 2 - review of the safety factors; and a further update in December 2018 on point 1 - review of the Clinical Model Principles and point 3 - review of the clinical service delivery model, which consisted of staff consultation activities via an online questionnaire in December and January 2019 and staff, stakeholder and patient workshops in February 2019.

The staff workshop session generated two areas of consensus. There was a need to review the culture within the hospital with a focus on clinical empowerment and strengthened clinical management to engage and develop staff. There was an opportunity to consider structural change with the emergence of two options to the configuration of wards and patient pathway. Option 1 was three hubs operating a three ward system of progression with Ward 1 being admissions and acutely unwell patients, Ward 2 continuing care and Ward 3 rehabilitation / pre transfer with a specialised Intellectual Disability service with one or two wards. Option 2 was a varying hub function model with two admission wards, one or two Intellectual Disability wards, Five or four continuing care wards and two rehabilitation wards with Skye centre integration.

3 ASSESSMENT

Staff Engagement Process

Following the Staff Workshop on the 6th February, Stakeholder Workshop on the 25th February and Patient Workshop held by Patient Partnership Group on the 18th February, there has been an invitation for staff to feedback comments and also a programme of planned engagement with staff groups. To date 204 clinical staff and over 30 non clinical staff have attended the engagement meetings, 14 individuals have submitted written responses representing Nursing, Social Work, Pharmacy and Psychology.

Hub leadership teams have included discussions of the Clinical Model Review in their team meetings, with Hub Leaders identified as champions for engagement on the review. A presentation has been shared to ensure consistency of message and a staff bulletin has been issued.

Reactions from staff groups to the Clinical Model Review

From the Staff Engagement to date there has been consistent agreement and welcoming of change with the principles of:

- More tailored security based on patients needs, least restrictive where appropriate
- Sense of progression for patients
- Integration between rehab wards and the Skye Centre
- Intellectual Disability patient's needs to continue to be meet in a specialized ID service, possibly with 2 wards
- Patient mix more tailored with admissions and clinical acuity accommodated in specific areas

Key messages emerging from feedback
The engagement process has identified a wide range of issues that are important to consider;

- There is a need to differentiate structural change form organisational change process, both are vital in being an effective organisation however they require different process to deliver change.
- Patient mix at present is a significant issue
- No consensus on either Option 1 or 2 being preferred, with Option 1 being more similar to current position and Option 2 viewed as more transformative.
- Some concern about the financial viability of different options
- There is agreement on alignment of Skye Centre to Rehabilitation wards
- Patient needs should be a priority in a redesign process.

Themes form staff engagement
Leadership, culture and team working
Patient pathway
Staff wellbeing, recruitment and retention
ID service
Continuity of care
Patient Engagement in activities
Wider Forensic Network
Safety and Security
Physical Environment

Options Appraisal Process

A feedback session was held in May to provided feedback to Heads of Service and Senior Clinicians on staff engagement to date, themes emerging and to provide an overview of the options appraisal process. From this meeting it was emphasized that activities to support cultural change would be taken forward to support organizational effectiveness via different routes and that the Clinical Model Review should focus on consideration of structural change and change to the patient pathway. It was agreed from the meeting and from feedback offered through the Clinical Forum that there was a need to detail the options more fully to ensure clarity of each and enable effective scoring against benefits. A short life working group has been established with the Clinical Forum to work up the options and provide clarity on their meaning. The Clinical Forum is also taking forward engagement work to further scope out current options and potentially identify additional options with other High Secure Hospitals to provide assurance that all possible options for change have been considered. The scoping work will be carried out by a multi disciplinary team representing the Hubs and disciplines to ensure effective engagement and collaboration.

A set of Benefits Criteria have been developed and consulted on, based on the priorities and key themes that emerged from staff engagement process. These are attached as appendix 1 together with an overview of the Options Appraisal Process. Financial analysis of the options is ongoing and Situational analysis including review of workforce implications and risks will also be carried out. The Benefits Criteria will be weighted in collaboration with Heads of Service and Clinical Leads. Following this the options will be scored.

Next Steps

Following full working up of the options and then completion of the Options Appraisal Process, it is envisioned that an emerging preferred option would become apparent. This would be shared with Heads of Service and Clinical leads for information and would be offered to the Board with a draft implementation plan for consideration and approval. The timescale for this we would expect to be in October 2019.

4 RECOMMENDATION

The Board is invited to note the progress made on the Clinical Model Review

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MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Corporate objectives of high quality clinical care and staff experience
Workforce Implications	Workforce implications that may arise from the review of the Clinical Model will be formally assessed at options appraisal stage
Financial Implications	Financial implications that may arise from the review of the Clinical Model will be formally assessed at options appraisal stage
Route To Board Which groups were involved in contributing to the paper and recommendations.	SMT
Risk Assessment (Outline any significant risks and associated mitigation)	Risks that may arise from the review of the Clinical Model will be formally assessed at options appraisal stage
Assessment of Impact on Stakeholder Experience	Through stakeholder workshop
Equality Impact Assessment	Not formally assessed
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	Not relevant at this point
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One □x There are no privacy implications. □ There are privacy implications, but full DPIA not needed □ There are privacy implications , full DPIA included.

Appendix 1

Clinical Model Options Appraisal

Options Appraisal Process

The process to review the options for the clinical model review and assess each option against benefits criteria is outlined below.

Benefits Criteria

The table below provides the agreed benefits criteria for the assessment of the clinical model options. The agreed options will be assessed against each benefits criteria, and these will be weighted to provide an order of importance and priority. It is important that the benefits criteria are clearly defined to ensure that the scoring of each for the models is accurate and informed. All reference to Forensic Mental Health Services includes services for both Major Mental Illness and Intellectual Disability.

Benefits Criteria

Ref	Description	Definition
A	Legislation and policy environment	This option should provide a safe service for all staff patients volunteers and visitors. All clinical risks associated with the options should be assessed and managed. The option should meet all the legal and policy requirements expected of a high secure forensic mental health service.
B	Opportunity for staff specialism and development	This option should provide staff the opportunity to develop their professional skills and expertise and specialise in areas of clinical service delivery appropriate to the needs of patients and requirements of the hospital
C	Opportunity for patient engagement in on Hub activities	This option should provide adequate opportunity for patients to engage in and experience a range of Hub activities relevant to their needs and abilities
D	Opportunity for patient engagement in off Hub activities	This option should provide appropriate opportunity for patients to engage in and experience a range of off Hub activities relevant to their needs and abilities
E	Ability to reconfigure service to meet changes in external factors	The extent to which this options support sustainability of the service is important to ensure we plan for any potential changes in external environment and can adapt to these, e.g. Increase or decrease in admissions. The option should be able to accommodate changes in patterns of care and the changing needs of the population over the longer term.
F	Continuity of care	The option should support the premise that during their time in the state hospital patients can expect to have their care delivered by a substantially stable team of clinicians who develop therapeutic relationships to support the patient in their recovery.
G	Ability to individualise security measures	The option should be flexible and support individualised security approaches so that the least restrictive security is applied for each patient. Patients can expect to have a progressive and risk assessed approach to security through this option without

		detriment to the overall safety of the hospital.
H	Disruption to patients and staff	The degree to which this option would impact on the requirement of staff and patient moves to implement the clinical model. The extent to which clinical services can be maintained during any implementation phase and the timescale of the implementation phase should be considered.
I	Progression through hospital	The option should outline a clear pathway for progression through the hospital which is defined and understood by staff and patients.
J	Physical environment	The physical environment of patient bedrooms, wards, hubs and the Skye centre is suitable to provide safe care under the new model. Care should be provided in an environment that will maximise benefit to the individuals to aid their health and wellbeing. This includes the design and functionality of the building.

Weighting of benefits criteria

Following agreement of the benefits criteria, the benefits matrix will be completed. To do this, each benefit will be compared against one another and ranked (weighted) . This weighting will be developed through individuals identifying the respective priorities of each of the benefits criteria against the others , producing an overall weighting. This can then be used for scoring.

Scoring of options

The proposed options will be scored based on the weighted benefits criteria. This will produce an overall position for the clinical assessment of what option best suits future needs of the hospital. This will be considered together with the Financial and Situational analysis to produce a final Decision Analysis and the identification of a preferred option.

Financial Analysis

This will involve capturing the projected costs of the option proposed. Affordability is not considered as part of the benefits criteria

Sensitivity Analysis (Risk, Reputation Workforce)

This will involve mapping out the risks, assumptions and workforce requirements for each model to fully understand the implication of each option. It will also consider any uncertainty in the proposed models and the impact this could have on the hospital

Decision Analysis

Data on costs and benefits are brought together with the risks and uncertainty analysis and summarised using marginal analysis. The **emerging preferred option** should then be identified with clarity of the range of strategic analysis carried out to support the preferred option.

Paper No. 19/37

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	20 June 2019
Agenda Reference:	Item No: 8
Sponsoring Director:	Director of Nursing and AHPs
Author(s):	Director of Nursing and AHPs
Title of Report:	Health and Care Staffing Bill
Purpose of Report:	For noting

1 SITUATION

The Health and Care (Staffing) (Scotland) Bill was unanimously passed by parliament on 2 May 2019 and is currently awaiting Royal Assent at which time it will become an Act. Statutory guidance is currently under development, and enactment of the legislation is anticipated in mid-2020. It is likely that there will be a phased approach to the implementation of the requirements of the Bill.

The purpose of this paper is to ensure that the Board is sighted on the overall requirements of this legislation, the role of the Board, and specific actions that need to be progressed to ensure readiness for enactment of the legislation. This paper also sets out work under way to ensure we are prepared to meet our requirements in response to the Bill.

2 BACKGROUND

The aim of the Health and Care (Staffing) (Scotland) Bill is to provide a statutory basis for the provision of appropriate staffing in health and care service settings, enabling safe and high quality care and improved outcomes for service users. It will do this by ensuring that the right people with the right skills are in the right place at the right time, creating better outcomes for patients and service users, and supporting the wellbeing of staff.

The Bill does not seek to prescribe a uniform approach to workload or workforce planning. Instead, it enables the development of suitable approaches for different settings. It will:

- provide assurance that staffing is appropriate to support high quality care, identify where improvements in quality are required and determine where staffing has impacted on quality of care

- support an open and honest culture where clinical/professional staff are engaged in relevant processes and informed about decisions relating to staffing requirements

- enable further improvements in workforce planning by strengthening and enhancing arrangements already in place to support transparency in staffing and employment practice across Scotland and through the use of, and outputs from, the Common Staffing Method and associated decision making processes

- ensure the clinical voice is heard at all levels by ensuring arrangements are in place to seek and take appropriate clinical advice in making decisions and putting in place arrangements in relation to staffing including: identification of any risks; mitigation of any such risks, so far as possible; notification of decisions and the reasons why and a procedure to record any disagreement with the decision made

3 ASSESSMENT

All territorial Health Boards and those Special Health Boards delivering patient facing clinical services are covered by the legislation, which is underpinned by guiding principles.

These principles are:

- that the main purposes of staffing for health and care services are to provide safe and high-quality services and to ensure the best health or care outcomes for service users.
- that staffing for health and care services is to be arranged while:

    - Improving standards and outcomes for service users;
    - Taking account of the particular needs, abilities, characteristics and circumstances of different service users;
    - Respecting the dignity and rights of service users;
    - Taking account of the views of staff and service users;
    - Ensuring the wellbeing of staff;
    - Being open with staff and service users about decisions on staffing;
    - Allocating staff efficiently and effectively;
    - Promoting multi-disciplinary services as appropriate.

A range of duties on Health Boards are described in the Bill:

Duty to ensure appropriate staffing
Every Board must ensure that **at all times** suitably qualified and competent individuals from such a range of professional disciplines as necessary, are working in such numbers as are appropriate for the health, wellbeing and safety of patients or service users, and the provision of high-quality health care.

Duty to ensure appropriate staffing: agency workers.
The Board should not pay more than 150% of the amount that would be paid to a full-time equivalent employee, when securing the services of an agency worker**.** Where a Health Board does pay more than 150% they must report quarterly to Scottish Ministers the number of times this has happened, the amount paid and the reasons for it.

Duty to have real-time staffing assessment in place
The Board needs to put in place arrangements for the identification of risk relating to staffing which affects the health, wellbeing or safety of patients by any member of staff and possible mitigation of that risk by the individual with lead professional responsibility where the risk is identified.

The Board is also required to raise awareness amongst staff and encourage use of the procedures, and train those who will be implementing the arrangements, as well as ensuring they have adequate time and resource to implement the procedures.

Duty to have risk escalation process in place
This duty requires the Board to put in place and keep arrangements for escalation of risks which have not been mitigated under the real time assessment process. These arrangements must include procedures for the reporting of risk to a more senior decision maker with a requirement for that decision maker to seek and have regard to clinical advice in reaching a decision as regards mitigation.

Duty to have arrangements to address severe and recurrent risk
The Board must put in place arrangements to collate risks that have been escalated to such a level as they consider appropriate, and to identify severe or frequently recurring risks and record and report these as necessary, including to Board level where appropriate. The Board must mitigate these so far as possible and identify actions to prevent recurrence where possible. This will ensure the Board is aware of all severe risks and of trends of frequently recurring risks to be identified and the need for longer term mitigation to be put in place to be assessed.

Duty to seek clinical advice on staffing
Arrangements must be in place to ensure appropriate clinical advice is sought and taken into account when making decisions and putting in place arrangements in relation to staffing. These arrangements apply at Board level and at all levels throughout the organisation.

As such when the Board makes decisions in relation to staffing at Board level they must ensure the Nurse and Medical Directors have provided clinical advice and the advice provided is taken into account in decisions. Where decisions are made that are contrary to that advice the Board will be required to explain the decision, identify any risks that the decision may cause, any mitigatiON they have put in place and how they will monitor the risk going forward.

The Board must also have procedures in place for those who provided the clinical advice to record disagreement with decisions made that are contrary to the advice given.

The Director of Nursing and AHPs and Medical Director will need to report to the Board quarterly on each aspect of the Bill which includes their assessment of how well the requirements are being achieved. They can report more frequently if they have any concerns. The Board must have regard to these reports.

Duty to ensure adequate time given to clinical leaders
Individuals with lead clinical professional responsibility for a team of staff receive sufficient time and resources to undertake their professional and organisational responsibilities, including their overall supervisory role in meeting the clinical needs of the patients in their care, managing and supporting the development of their staff and to lead the delivery of safe, high-quality and person-centred health care. This includes, for example, Senior Charge Nurses.

In practice the Board will be required to provide evidence that clinical team leaders are given sufficient time to undertake their role. This will allow for flexibility in the amount of time afforded to this role depending on the size and type of team and the local context in which it operates.

Duty to ensure appropriate staffing: training of staff
The Board must ensure that its employees receive appropriate training as it considers appropriate and relevant, to ensure the health, wellbeing and safety of patients and the provision of safe and high-quality health care. This must be supported by adequate time and resources. This will ensure that professional development of staff in their role.

Duty to Follow the Common Staffing Method

The Board will be required to use a more detailed method for determining staffing establishments which is described as the 'Common Staffing Method'. This will require the Board to:

- Apply specialty specific and professional judgement tools
- Take account of:
    - quality measures, local context and current staffing levels and skill mix
    - Any assessment by HIS or other relevant assessments
    - comments from staff and service users relating to staffing
- Identify risk and take steps to mitigate risk
- Take account of appropriate clinical advice

The Common Staffing Method is set out in appendix 1.

Reporting
The Board will be required to publish and submit to ministers an annual report which details how we have complied with the duties in the Bill.

Scottish Ministers must collate these reports and produce a statement detailing how they have or will use the information in their policies for staffing in the Health Service.

Progress to date
In preparation for the legislation coming into force, the Board is receiving funding until September 2020 to employee a part time workforce lead to take forward this work.

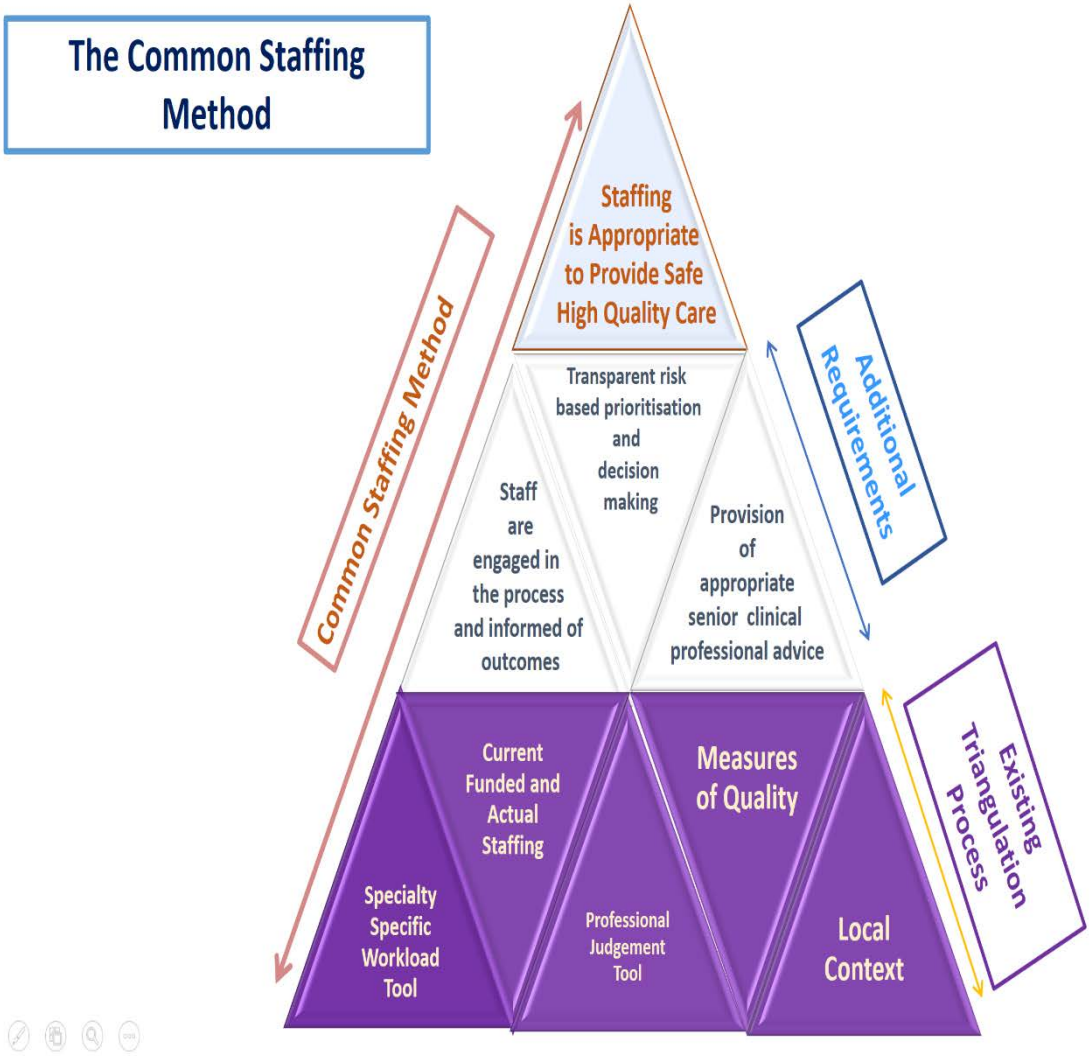
The workforce lead is working closely with Healthcare Improvement Scotland to prepare for meeting the requirements set out in the Bill, particularly the Common Staffing Method.

Preparatory work has been completed to pilot the workforce tools in Lewis Hub in June 2019, with a view to completing this work in all wards by the end of this year. The exact timing of this will be influenced by the work on the clinical service delivery model, as we need to agree on the function of each ward going forward with this informing the local context and professional judgement elements of the Common Staffing Method.

4 RECOMMENDATION

The Board is invited to **note** this update on safe staffing legislation, and invite a further update at the October meeting of the Board.

Appendix 1


The Common Staffing Method
Staffing is Appropriate to Provide Safe High Quality Care
Common Staffing Method
Additional Requirements
Existing Triangulation Process
Transparent risk based prioritisation and decision making
Staff are engaged in the process and informed of outcomes
Provision of appropriate senior clinical professional advice
Current Funded and Actual Staffing
Measures of Quality
Specialty Specific Workload Tool
Professional Judgement Tool
Local Context

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Sets out the Board's legal duty as it relates to safe staffing.
Workforce Implications	The common staffing method will be applied which may have implication for the size and shape of the clinical workforce.
Financial Implications	Outputs from the common staffing method and subsequent advice to Board may have financial implications. These are unquantified at this point in time.
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)	No significant risks identified in terms of readiness for legislation being enacted. Financial risk unquantified as will be informed by outputs from safe staffing method and subsequent advice to the Board.
Assessment of Impact on Stakeholder Experience	Not formally assessed.
Equality Impact Assessment	Not formally assessed.
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	None identified to date.
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One ✓ There are no privacy implications. □ There are privacy implications, but full DPIA not needed □ There are privacy implications , full DPIA included.

Paper No. 19/38

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	20 June 2019
Agenda Reference:	Item: 9
Sponsoring Director:	Director of Nursing and AHP's
Author(s):	Skye Centre Manager
Title of Report:	Skye Centre 12 Month Update Report
Purpose of Report:	Update on patient activity services within the Skye Centre

1 SITUATION

This report provides an update on patient activity services within the Skye Centre. It details service activity levels for the period 1 June 2018 to 31 May 2019.

2 BACKGROUND

This report provides an update on key pieces of work undertaken over the past 12 months and future developments are also highlighted within the report.
Over the past 12 months the dedicated, professional and flexible approach from the Skye Centre staff group has enable them to continue delivering a quality service to our patients. The majority of recommendations stated in last year's report have been achieved.

3 ASSESSMENT

Key Pieces of Work Undertaken During the Year

- Patient Active Day
- Patient Timetable
- Redesign of Woodwork Centre
- Vocational Qualifications/Course
- Events
- Outcome Measures

Identified Issues and Potential Solutions

- Recruitment
- Sickness

4 RECOMMENDATION

Future Areas of Work and Potential Service Developments

- Vocational Activity Space
- Patient Day Project
- Patient Timetable
- Outcome Measures
- Provision of Activity Out With 9-5
- Efficiency Savings Targets

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MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Supports the KPI related to patient activity
Workforce Implications	Considered under section 5
Financial Implications	None
Route To SMT Which groups were involved in contributing to the paper and recommendations.	Clinical Governance Group
Risk Assessment (Outline any significant risks and associated mitigation)	None
Assessment of Impact on Stakeholder Experience	Risk of not delivering appropriate access to services
Equality Impact Assessment	N/A
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	N/A
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One x There are no privacy implications. □ There are privacy implications, but full DPIA not needed □ There are privacy implications , full DPIA included.

THE STATE HOSPITAL BOARD FOR SCOTLAND

SKYE CENTRE

12 MONTH UPDATE BOARD REPORT

1 June 2018 – 31 May 2019

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	1 June 2018	
Review Date	31 May 2019	
Responsible Officer (e.g. SMT lead)	Mark Richards, Nursing & AHP Director	

Contents

Section 1 – Introduction

This report provides an update on patient activity services within the Skye Centre. It details service activity levels for the period 1 June 2018 to 31 May 2019. Key pieces of work undertaken and future developments are also highlighted within the report.

Over the past 12 months the dedicated, professional and flexible approach from the Skye Centre staff group has enabled them to continue delivering a quality service to our patients. The majority of recommendations stated in last year's report have been achieved. The redesign of the Woodwork space is complete and patients were involved in the refurbishment supporting a joint initiative with staff to paint the area. This is now available as a bookable activity space.

Every effort has been made to ensure all staff vacancies are being recruited to. The long standing Band 5 Gardens post has been filled and the successful candidate has a wealth of horticultural knowledge and training experience and comes with the relevant SQA assessor qualification. The service also successfully appointed a Band 6 Senior Occupational Therapist in February 2019 and in the short time they have been in post have enhanced and positively supported service delivery.

2018/19 Recommendations Update
Comparison with last year's report

Recommendation Description	Achieved/Not Achieved	Comments
Efficiency Savings Targets For the financial period 2018/19 the agreed savings target is £187k. The necessary steps have been identified to meet the agreed savings target.	Achieved	The Skye Centre Service achieved the savings target identified for 2018/19.
Redesign of Woodwork Centre To progress the proposed change, re Skills Mix Review further work and discussion required to take place at H&S Committee and SMT. This change will support an integrated multi-disciplinary model to facilitate groups.	Achieved	The activity space was cleared of the woodwork machinery and modifications carried out. An SBAR was submitted to H&S Committee and SMT and recommendations for the Skills Mix Review were support. Room is now an allocated bookable space which can be accessed by a variety of disciplines.
Onelan System The system will go live end of June 18 within the Skye Centre. Feedback will be sought from patients and staff re the information displayed/appropriateness/usefulness /accessibility etc. The system will then be implemented in Arran Hub in order to providing wider testing of the system after which it will be rolled out across all wards.	Achieved	The Onelan system was introduced in July 2018 and is currently being used by all professional bodies across the site to promote and advertise up and coming activities. Onelan also provides patients with menu choices available on that day including any changes and this is carried out by the Dietetic Assistant and Catering staff.

Recommendation Description	Achieved/Not Achieved	Comments
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.	Achieved	Three social evening activities were planned commencing June '18. These were well attended and feedback from patients was very positive. The 'Events Committee' group, established during a TSH3030 project last year, has been introduced into the Skye Centre to offer patients across the hospital an opportunity to participate in a voluntary role as an events committee member.
Supporting Healthy 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.	Achieved	Health & Wellbeing plans have been developed in consultation with all relevant disciplines. The Sports and Fitness and Shop staff have been trained in the completion of the relevant sections and are successfully completing these in line with the implementation programme.
Outcome Measures Further to discussions held at the Mental Health Practice Steering Group and the ongoing work related to Outcome Measures, The 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. 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.	Achieved	Research Manager attended and supported the Skye Centre Leadership Group to discuss objectives related to the outcome measures report. The information related to our service has continued to be revised over the past year in order to best reflect the outcomes related to the service. A number of formal assessments are now included in the Induction process including a range underpinned by the Model of Human Occupation and others such as the Allen Cognitive Level Screen and the Peavy Social Comportment tool.
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.	Achieved	The Patient Day project was extended to include Arran 2 on 23rd August 2018, with this ward aiming to deliver the Patient Day model 2 sessions a week, however this was reduced to 1 session in November 2018. By December 2018 it was agreed that the Patient Day model would be implemented across the remaining 2 hubs (Mull & Iona) and Arran 2 session times would be reviewed to increase this back to 2 sessions as of January 2019. The extended project was successfully implemented the week

Recommendation Description	Achieved/Not Achieved	Comments
		commencing 7th January 2019 across all 4 hubs and has been maintained to present date.
Recruitment The recruitment is at various stages in order to fill vacancies. Discussions are ongoing to review the current workforce number and skill mix to ensure succession planning is built in to future service delivery to meet the needs of our patients.	Ongoing	Every effort has been made to address the ongoing vacancies across the service. The recruitment process for these posts is ongoing. The long standing Band 5 Gardens post has successfully been recruited to. Staffing contingencies continue to be put in place to minimise the disruption to this service until the vacancies are filled. The registered staff mix was reviewed and a band 6 Senior Occupational Therapist was also successfully appointed in February '19.
Patient Timetable A small sub group has been established with representation from the Skye Centre, AHP and Person Centred Improvement Team 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.	Partially Achieved	The development of the Patient timetable was commenced in December 2018. A multidisciplinary sub group was established with representation including Nursing, Psychology, Skye Centre, Medical, E-Health and AHP. Training on how to use the newly developed system was carried out in March 2018 and a pilot commenced in April 2019 within Lewis 2 and feedback has been received. The Sub group are meeting in June 2019 to discuss and make the necessary changes received from the Pilot prior to implementing across the site.

Overview

The Skye Centre service is defined by four Activity Centres (Patient Learning, Sport & Fitness, Craft & Design, and Gardens & Animal Assisted Therapy) 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 Person Centre Improvement Team (Patient Partnership Group - *PPG*, Christian Fellowship and Multi Faith Services), the Psychological Therapies Service and Allied Health Professions staff. The Advocacy service are also located within the building. 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. In February 2019 the service successfully appointed a Senior Occupational Therapist to join the team.

The Skye Centre staffing establishment is presently 38.33 wte, the actual staff in post is 33.33 wte due to vacancies. The service is currently operating with 6vacancies (5wte).Two of these posts have successfully been recruited to and the post holders will commence in July 19 and August 19. The recruitment process for the remaining posts is ongoing. Adjustments have been made to internal staff deployment across the service to mitigate against the temporary loss of these posts.

Volunteers
The Skye Centre service continues to work alongside the Person Centred Improvement Team to support the role of volunteers across the service. The number of volunteers has increased from 4 to 5 over the last 12 months. The recruitment process has successfully identified an additional 2 new Volunteers for the Patient Library and the Sports & Fitness and the induction process is underway to enable them to commence in June 2019. There are also 3 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.

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
- Vocational & Work 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 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 worked collaboratively with the Art Psychotherapist delivering group interventions in the Craft & Design Centre and Skye Centre staff have worked jointly with the Music Therapist to deliver the Community Choir, held in the Vocational Activity room.

Section 2 - Governance & Management Arrangements

Governance Arrangements

Formal update 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 are further approved by the Senior Management Team at which the Skye Centre service is represented. Performance data related to the Skye Centre is also reported to the Clinical Governance Group on a quarterly basis.

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, Senior Occupational Therapist and support staff group. There are 3 Charge Nurse posts across the service each with responsibility for the day to day supervision of discrete areas of the service.

Section 3 - Key Performance Indicators

Figure 1: Key Performance Indicators (KPI's) targets for activity are set out as key performance indicators 2018-19 and comparison with the previous 5years

Performance Indicator	Target	18/19	17/18	16/17	15/16	14/15
Patients will be engaged in off-hub activity centres	90%	84%	79%	83%	81%	73%
***Patients will engage in meaningful activity on a daily basis	100%	-	-	-	-	-

****The definition "Meaningful Activity". Requires to be defined therefore data is presently not reported on for this KPI.*

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

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

Safe

The nursing staff within the Skye Centre service are offered the opportunity to receive individual 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 – x6 individual sessions and 8 group sessions facilitated by a Clinical Nurse Specialist allocated from the Psychological Therapies Service. Our support staff participated in 7 group supervision sessions facilitated by a member of the Nurse Practice Development Team.

Figure 2 below provides an overview of the total number of incidents occurring within the Skye Centre over the past 12 months. There has been an increase in the number of incidents reported involving the Skye Centre from 86 to 98. The number of security incidents increased – 25 were related to user error at Hub/reception level during the process of booking patients to attend the Skye Centre using the Patient Movement Tracking System. This has since been resolved.

The delivery of activities 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.

Figure 2: Total number of incidents occurring within the Skye Centre between 1 June 2018 and 31 May 2019. Broken down into Category Types

Incident Category	1 Jun 2018 - 31 May 2019	1 Jun 2017 - 31 May 2018	1 Jun 2016 - 31 May 2017
Health & Safety			
Assault	2	2	3
Attempted Assault	1	3	3
Behaviour	8	12	18
Sexual	4	2	4
Verbal aggression/abuse	4	12	9
Struck	0	3	2
Staff/Patient Injury	16	12	19
Slip/Trip/Fall - Patient	11	10	12
Slip/Trip/Fall - Staff/Other	1	1	1
Moving & Handling	0	0	1
Fire Alarm Activation	1	0	0
Injured by animal	2	0	3
Staff Resource Issue	0	0	5
	50	**57**	**80**
Security			
Breaches	5	10	14
Control of Patient Whereabouts	25	0	0
Prohibited/Res Items	1	0	0
Keys	0	2	1
Other	6	6	10
	37	**18**	**25**
Communication/Information Governance			
Breach of Patient Confidentiality	2	1	3
Breach of Staff Confidentiality	0	1	0
Communication Breakdown	3	0	0
	5	**2**	**3**
Equipment/Facilities/Property			
Equipment Malfunction	3	3	5
Theft	2	0	0
Contact	0	3	6
Damage	0	0	2
	5	**6**	**13**
Infection Control			
Exposure	0	0	2
Laundry	1	0	0
	1	**0**	**2**
Totals	**98**	**86**	**123**

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). Our newly appointed Senior Occupational Therapist has also supported the use of standardised outcome measures within the induction process for new admission patients and also during OT treatment interventions.

There are presently a range of Patient Learning Outcomes and KPIs in place across the service and these are reported annually in a separate report to the Board. This report was received in February 2019 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 do not routinely attend weekly Clinical Team meetings and Annual CPA Review meetings however every effort is made to ensure staff input is available as and when the clinical need is indicated.

During the period of the report there were 94 annual reviews and the Skye Centre VAT form completion was 100%. Figure 3 below outlines the ICP data for the previous year.

It should be noted that in relation to the T&R VAT if we strip out the patients who do not have Skye Centre placements the report completed figure would be 92.5%. There were 5 occasions where a report was not carried out.

Figure 3 Skye Centre ICP DATA June 2018 – May 2019

	June 18 – May 2019	**June 17 – May 2018**
Treatment and Rehabilitation VAT	n=94	n=100
Skye Centre report available	65% (61)	72% (72)
Those not done		
Case Review date changed	2	1
No reason		1
No SAC placements	26	25
Patient unsettled presentation		1
Staff sick leave	3	
Staff not aware of review	1	
Not done prior to Case Review	1	
SAC Rep discuss content of report with patient prior to Case Review	n=94 (59)	
Those not done		
Case Review date changed	2	
No reason	1	
No SAC placements	26	
Staff not aware of review	1	
Not done prior to Case Review	1	
Patient unsettled presentation	1	
Staff sick leave	3	

Admission VAT	n=22	n=22
Admission Fitness Assessment completed	81.8% (18)	45.5% (10)
Joint Admission/Discharge CPA		
No Reason		2
Patient unsettled presentation		3
Not referred by CTM	2	6
Not required as Re-admission		1
	2	
	n=32	
Skye Centre Induction Report	37.5% (12)	
Those not done		
No outstanding need	1	
No reason	4	
Not referred by CTM	1	
Not required as re-admission	2	
Patient declines	1	
Patient unsettled presentation	3	
Staffing issues	3	
Still in progress	5	

The Skye Centre Induction is now facilitated by the Senior Occupational Therapist and Skye Centre support staff and completion of the induction reports has been consistently applied since April ’19. The completion of these reports will be monitored by the Senior Charge Nurse.

Skye Centre nursing staff attendance at annual case reviews was recorded at 1.1%. This has been the case for the past few years. This matter was raised at the May 2019 Clinical Governance Group. Whilst the benefit of nursing staff attending the CPA review is widely acknowledged, the staffing is prioritised to ensure that activity centres remain open. This situation is unlikely to change in the near future and it was agreed that the Skye Centre Manager would identify other appropriate forms of communication to ensure valuable clinical information related to activity is shared with the wider clinical teams.

Person – Centred

The Skye Centre service continues to comply with the principles outlined in the revised NHS Complaints & Feedback Procedure and staff are 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 an increase in the number of complaints from patients regarding the Skye Centre within the last 12 months. Figure 4 below outlines the number of complaints received during the reporting period. A total of **15** complaints were received (8 upheld, 1 partially upheld, 4 not upheld, 2 withdrawn) in comparison to **11** during the previous year (4 upheld, 1 partially upheld, 4 not upheld, 2 withdrawn). Appendix 1 provides further detail for each complaint.

Figure 4

Skye Centre Complaints	1 June 2018 - 31 May 2019	1 June 2017 - 31 May 2018
Stage 1 Complaint	8	6
Stage 2 Complaint	5	3
Escalated to Stage 2	-	-
Withdrawn	2	2
Total	**15**	**11**

In previous years a number of complaints have been received from patients regarding access to services and centre closures. There were 9 complaints received in relation to this over the past year, an increase from 6 received during 2017/2018. Included in this total were 3 complaints related to access to services which were not upheld and 4 complaints related to the delay in providing access to the Hairdressing service. This matter has since been resolved and the service now has a service level agreement in place.

Figure 5 below provides details of the number of planned sessions over the past 5 years in comparison to the actual number of sessions attended. The number of planned sessions on offer to patients has increased along with the number of actual attendances over the past 12 months

Figure 5

	Scheduled Interventions	Number of interventions attended	% between planned and attended
2018/19	**21359**	**13793**	**35%**
2017/18	19187	12089	37%
2016/17	20853	13703	34%
2015/16	24032	19076	21%
2014/15	22712	16798	27%

A summary of the reasons for non-attendance over the past 12 months are detailed in Figure 6. Overall the figures related to non-attendance have increased and demonstrates an upward trend over the past 5 years. The centre closures have had the most impact on non-attendance over the past year.

Figure 6 Reasons for non-attendance at planned sessions

	2018/19	**2017/18**	**2016/17**	**2015/16**	**2014/15**
Closures (Unplanned – staffing, sickness, skill	2349	2368	2112	1511	1253
Closures (Staff redeployed to ward /outings to cover nursing deficits)	332	n/a	n/a	n/a	n/a
Closures (Inclement Weather)	189	637	104	45	69
Closures (Planned – Skye Centre Events)	145	n/a	n/a	n/a	n/a
Reduced patient numbers	497	n/a	n/a	n/a	n/a
Unable to attend due to ward closures	35	n/a	n/a	n/a	n/a
Deterioration in Mental Health	717	652	615	578	679
Physical Health Problem	441	479	521	518	765
Appointments with other Health Care Profession	620	589	534	429	517
External appointments	121	133	148	500	805
Tribunal/CMT/CPA Appointments	32	40	51	58	65
Patients Declined to attend schedule session	709	751	512	481	501
Patient seeing external visitor	47	30	14	79	94
Visit on ward	282	211	300	109	315
Discharge/Transfer/rescheduled sessions	327	249	277	219	101
Attending other Skye Centre activities using Dro	265	173	293	75	287
Other	458	786	417	54	463
Total	**7566**	**7098**	**5898**	**4656**	**5914**

New Admissions - Access to Skye Centre
35 patients were admitted from June 2018 to May 2019.

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

Hub Induction
From the 35 patients admitted during this period, on the advice of the ward nursing staff, 3 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.

Of the 32 patients who have participated in the Sports Hub Induction, over the last 12 months it has taken on average around 21 days from admission for a patient to complete the initial stage of the Sports Pathway i.e. Hub Gym Induction, in comparison to 40 days in 2017/18. 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.

Sports & Fitness Admission Assessment
From the 35 patients admitted, on the advice of the ward nursing staff, 3 patients currently remain too unwell to attend the Sports and Fitness Activity Centre to commence the physical fitness 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.

32 patients have participated in the Sports and Fitness Admission assessment. Over the last 12 months it has taken on average around 29 days from admission to assessment in comparison to 67 days 2017/18. The reasons for this delay can be attributed to the patients' poor mental health and presenting challenging behaviours.

Skye Centre Induction
From the 35 patients admitted, 3 patients were discharged before induction commenced, 1 patient did not require to redo the induction due to the time lapse between discharge and re-admission, 3 patients have not yet been approved by the Clinical Team to attend the induction programme and 3 patients are due to commence induction programme in June 2019.

25 patients over the last 12 months have commenced the induction programme and on average it took 42 days from admission to commence this in comparison with 107 days in 2017-18. The reasons for this delay can be attributed to the patients' poor mental health and presenting challenging behaviours.

The Induction Group is facilitated by the Senior Occupational Therapist and Skye Centre support staff and the report submitted to clinical teams now includes outcomes from the MOHOST assessment tool and Emotional Touchpoints evaluation.

Referrals

Referrals are received from the CTM for patients to attend a range of activities provided by the Skye Activity Centres In comparison to previous years the number of referrals has continued to decrease. Figure 7 below provides the referral data for the previous 4 year reporting period.

Figure 7 Number of Referrals:

	No. of referrals received	No. of patients
2018/19	85	45
2017/18	93	61
2016/17	170	117
2015/16	136	58

Figure 8 below provides the number of referrals received from each hub following discussion and approval from the respective Clinical Teams.

Figure 8

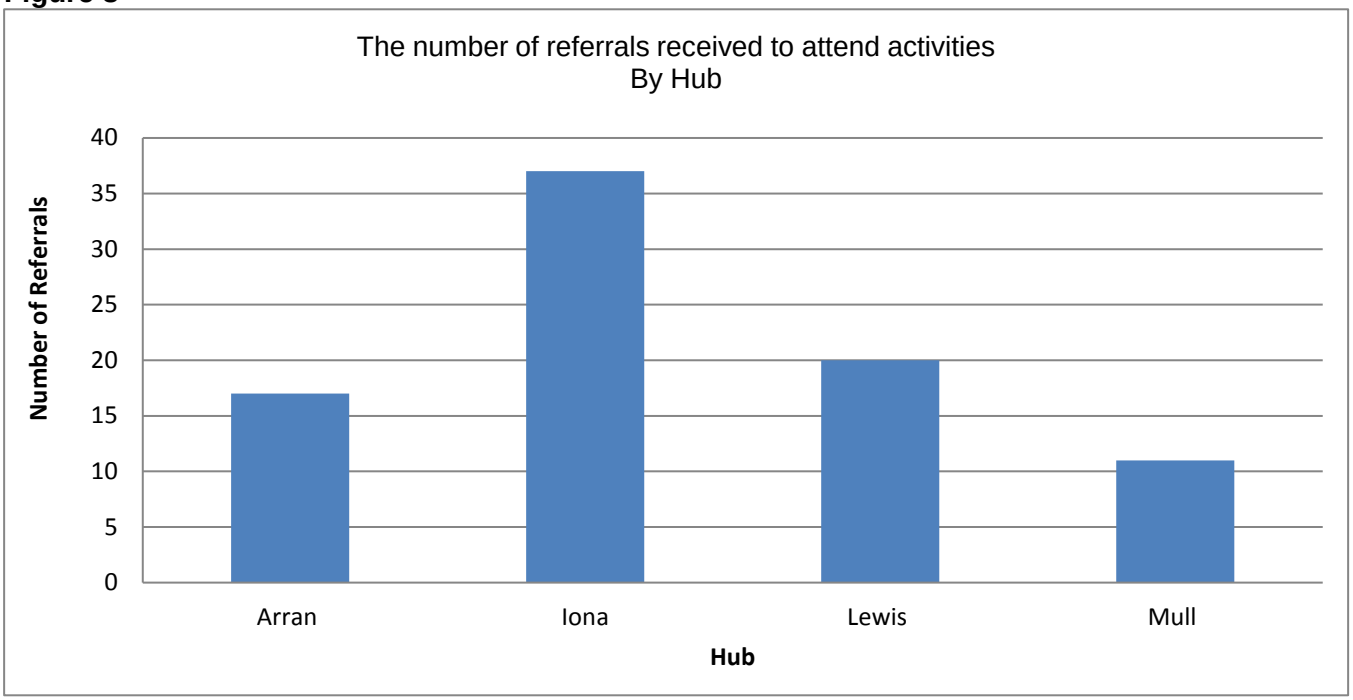
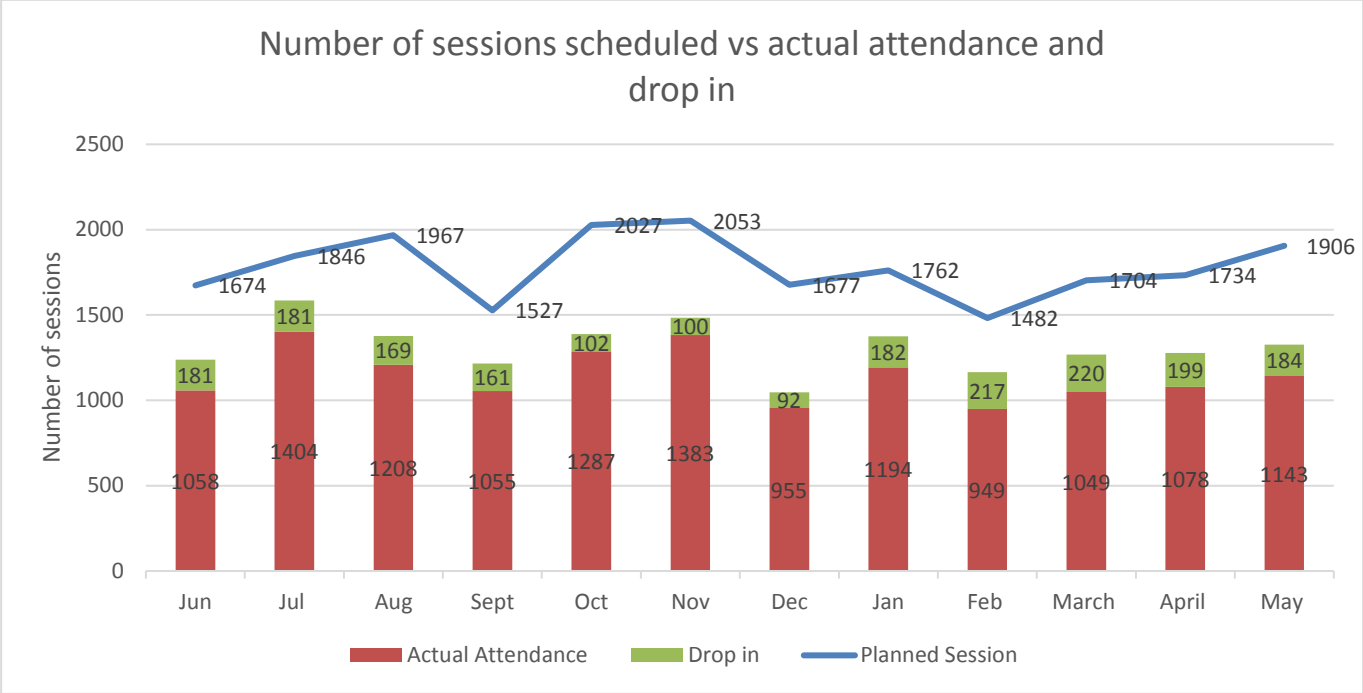


Figure 9 below details the number of activity sessions patients engaged in at the Skye Centre for the period June 2018 to May 2019.

There are currently 91 patients (84%) with planned activity sessions at the Skye Centre (data related to week commencing 28th May 2019). This is in comparison to 84 patients (79%) in 2018.

The patient engagement can range between 1 session and 10 sessions.

Figure 9



The number of actual attendances decreased in December 2018, which can be attributed to an increase in the number of centre closures during that month (n=27), related to vacancies and staff sickness and the other events (i.e. Skye Centre Christmas Lunches, Ward Christmas Parties)

Figure 10 provides an overview of the planned activity for each Activity centre against the actual attendance during the period June 2018 to May 2019.

Figure 10

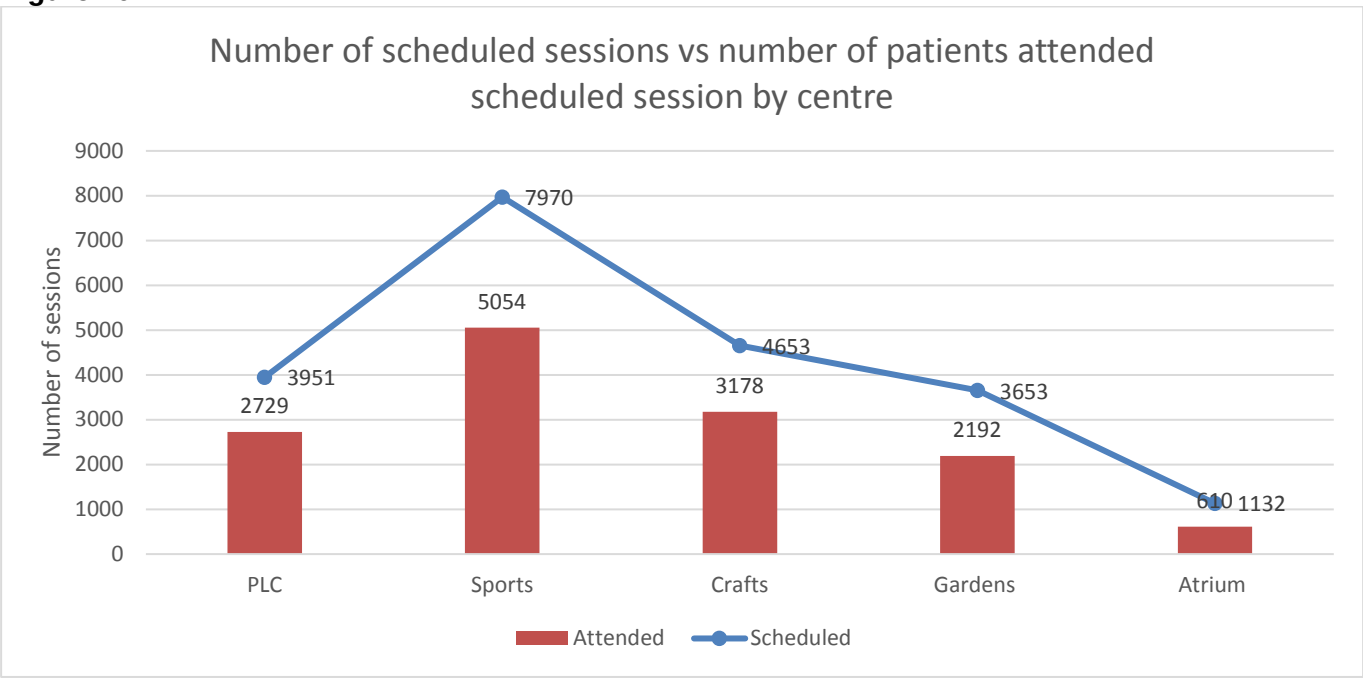


Figure 11 and Figure 12 provide information related to the caseload and waiting list for each activity centre. The 1 patient waiting for a placement in Gardens does have other placements within the PLC however due to the complex needs of this individual and requirement for increased staffing and tailored interventions, ongoing discussions are taking place with the Clinical Team to coordinate and facilitate a suitable time to attend.

Figure 11

Number of patients with scheduled participation			
	2018/19	2017/18	2016/17
PLC	36	37	36
Sports	64	55	64
Crafts	41	38	45
Gardens	33	43	40
Atrium	20	28	15

Figure 12

Number of patients on waiting list			
	2018/19	2017/18	2016/17
PLC	0	0	0
Sports	0	0	0
Crafts	0	0	0
Gardens	1	0	3
Atrium	0	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 Figure 13 demonstrates the number of sessions that individual patients are scheduled to attend (data related to week commencing 28th May 2019). It is evident that each hub varies in relation to individual patient engagement at the Skye 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 drop in activity or attendance at the Patient Day Project. The groups facilitated by the Person Centre Improvement Team are also recorded separately.

The number of activity sessions that 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.

Figure 13 - Skye Centre Sessions

Number of Planned sessions	Arran		Iona		Lewis		Mull		Total	
	2018/19 *22pts*	2017/18 *21pt*	2018/19 *32pts*	2017/18 *30pts*	2018/19 *33pts*	2017/18 *33pts*	2018/19 *21pts*	2017/18 *23pts*	2018 /19	2017/ /18
0	6	6	6	10	4	4	2	3	18	23
1	1	3	2	1	1	2	1	2	5	8
2	2	1	9	7	8	3	3	4	22	15
3	5	4	6	3	4	2	3	1	18	10
4	2	1	4	4	5	4	2	1	13	10
5	2	1	2	1	3	7	3	3	10	12
6	0	1	0	2	2	3	0	4	2	10
7	0	2	1	0	2	3	2	3	5	8
8	2	1	2	2	2	2	2	0	8	5
9	1	1	0	0	1	1	3	1	5	3
10	1	0	0	0	1	2	0	1	2	3

Arran
From the group of patients with no planned sessions at the Skye Centre – there has been no change for 3 of these patients over the past 12 months. Whilst these individuals do not have planned sessions 2 use their Grounds Access and regularly attend the Atrium on a Drop in basis for coffee/tea. 1 utilises his Grounds Access on a regular basis to walk in the grounds.

The remaining 3 patients - 2 are new admissions and awaiting approval for the Induction Group and 1 has withdrawn from planned sessions however utilises the Atrium from Ground Access to play scrabble with peers from other hubs

Iona
From the group of patients with no planned sessions at the Skye Centre – there has been no change for 4 of these patients over the past 12 months which is attributed to their poor mental health. However 1 of these patients does attend the Skye Centre supported by ward staff when his mental health allows in order to access the Atrium and the Sports and Fitness Centre.
The remaining 2 of patients regularly use the drop in to attend the Atrium from Ground Access for coffee/tea.

Lewis
From the group of patients with no planned sessions at the Skye Centre – there has been no change for 1 patient over the past 12 months however they occasionally use the drop in within the Atrium café. The remaining 3 patients do not access the service.

Mull
From the group of patients with no planned sessions at the Skye Centre – there has been no change for 1 patient over the past 12 months, however they regularly attend the Atrium with Psychology and OT staff. The remaining 1 patient does not access the service.

"What Matters to You' Campaign: 6th June 2018

The Skye Centre team, supported by the Person Centred Improvement Team, facilitated the 'What Matters to You?' event on the afternoon of 6 June 2018. The group was extended from the previous year to include the Volunteers and the Health Centre staff. A community forum was facilitated which enabled patients to share collective views. Patients who were well enough were supported to attend the Skye Centre 'What Matters to You?' event that day, with Skye Centre staff, volunteers and the Spiritual and Pastoral Care Team.

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.

An action plan (Appendix 2) from the event helped inform service developments and informed practical changes within individual activity areas e.g. Tea & Coffee available in the Health Centre waiting area, development of a sensory garden, more display areas available for patients art work and projects.

> "When they asked us what would make it better for you in the Health Centre, I said it would be good to have something to read and maybe some coffee cos it's not very nice when you're thinking about having a tooth out or your blood taken I didn't really think they would listen but now we have magazines and hot drinks, which is much better."
>
> Tinto Health Centre Patient, Jan 2019

This year's event will take place on 6 June 2019. The 'What Matters to You' day will follow the same format and the discussions will be again extended to include our AHP colleagues from the Arts Therapy service.

Section 4 – Key Pieces of Work Undertaken During the Year

Patient Day Project

The working assumption underpinning the Patient Day model, is that a ward would close for morning and afternoon sessions and the patients from that ward would spend their time within the Skye Centre. In doing so, more patients from that ward should be able to access more structured activity sessions on a regular basis.

The delivery of the model is underpinned by half the ward based staff from the closed ward working sessions within the Skye Centre (minimum n = 2), and the other half of the staff group working within the ward which has not closed or in the Hub.

The Patient Day Steering Group was re-configured in November 2019. Plans were put in place to extend the project across all 4 hubs commencing 7th January 2019. The group requested a more structured approach to eliciting feedback from all patients involved in the project.
This feedback initiative was facilitated by the Person Centred Improvement Team at the end of January 2019. Attending staff members were also approached to provide feedback at this time.

Performance Data

Performance data was gathered after each session across all wards participating in the project. Appendix 2 provides an overview of the period January 2019 – April 2019

Patient Feedback
33 pieces of feedback were elicited during from patients in all hubs. It should be noted that requests for feedback commenced in the last week of January. (Appendix 3). The data indicates that, as the project continued, patients were becoming more familiar with the concept and, as a result, many are beginning to understand the benefits of engaging in activity and interacting with a wider group of people.

Positive Outcomes
- Some patients now requesting drop-ins/placements as a result of this engagement
- Recognised value of providing additional opportunities for patients to socialise with peers
- Enjoyment in participating in board games, listening to music and watching films.
  Opportunities for Improvement/Discussion Points
- Atrium area – high stimulus environment, however initial patient contact / activity area.
- Need to learn more about what would make the experience less 'boring' – use of Interest Checklists in conjunction with the Occupational Therapy team
- Reintroducing patient volunteer role in café and developing similar in shop. (This is in the process of being implemented)

Staff Feedback
12 individual pieces of feedback were received from staff across all Hubs and the Skye Centre. It should be noted that requests for feedback commenced in the last week of January.

There were occasions whereby attending staff refused or avoided completing the feedback forms citing concerns that the forms were not anonymised. However the majority of feedback received was considered positive with staff reporting that patients are engaging and interacting well. The availability of games, films, Xbox etc. in the Atrium also have been reported back as very positive and comments being received such as "good atmosphere, patients relaxed". Another benefit reported by staff is the opportunity for patients to utilise ground access from the Atrium. Arran patients in particular are utilising this option on a regular basis.
Other feedback received from staff:

"Ensure that escorting staff are briefed on what is expected of them"

Ensure ward staff are aware of their roles and responsibilities when attending the Atrium with patients."

"Some patients don't want to attend the Skye Centre, ward staff can find it challenging to encourage patients to attend and participate when at the Skye Centre".

"Have more staff available in the Atrium at busy times to support tea/coffee etc."

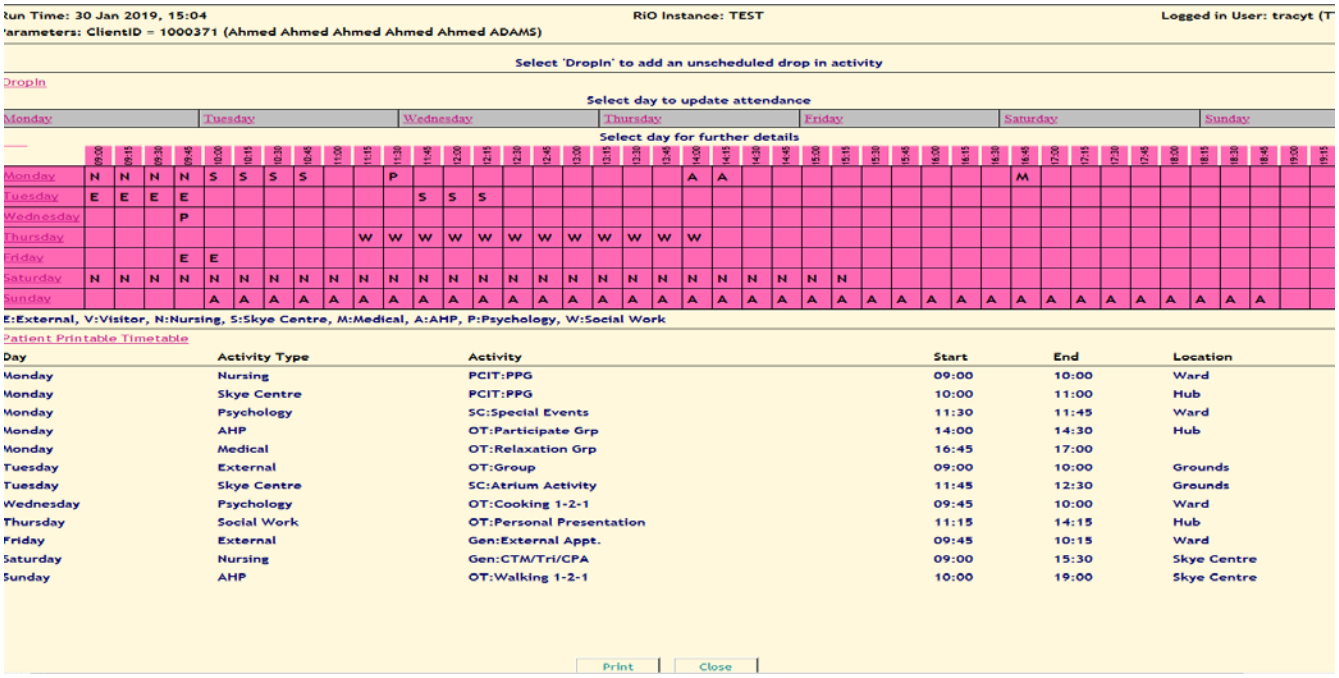
- Feedback has been provided on the Project feedback forms, Staff Feedback forms and verbally around the lack of space within the Atrium, especially on specific shop mornings i.e. Iona and Arran project days. When the Atrium Activity room is free this is noted to be beneficial to the project as it provides patients with another area to utilise if the Atrium is busy
- Concerns reported around the duplication of work and feedback when using the Project Feedback forms and individual staff feedback forms
- Concerns noted regarding the management of disassociated patients and the challenges this presents to ensure the risks are managed effectively whilst still promoting attending and access for patients

Patient Timetable

The development of the patient timetable was commenced in December 2018. A multidisciplinary sub group was established with representation including Nursing, Psychology, Skye Centre, Medical, E-Health and AHP. Training on how to use the newly developed system was commenced in March 2018 and a pilot commenced in April 2019 within Lewis 2 and feedback has been received. The Sub group are meeting in June 2019 to discuss and make the necessary changes received from the Pilot prior to implementing across the site.

Diagram 15 provides a view of the new timetable that has been developed on Rio and will be accessible to all clinicians in order to create a comprehensive activity schedule for our patients.

Figure 15 - Patient Timetable on Rio (activity scheduling)



Day	Activity Type	Activity	Start	End	Location
Monday	Nursing	PCIT:PPG	09:00	10:00	Ward
Monday	Skye Centre	PCIT:PPG	10:00	11:00	Hub
Monday	Psychology	SC:Special Events	11:30	11:45	Ward
Monday	AHP	OT:Participate Grp	14:00	14:30	Hub
Monday	Medical	OT:Relaxation Grp	16:45	17:00	
Tuesday	External	OT:Group	09:00	10:00	Grounds
Tuesday	Skye Centre	SC:Atrium Activity	11:45	12:30	Grounds
Wednesday	Psychology	OT:Cooking 1-2-1	09:45	10:00	Ward
Thursday	Social Work	OT:Personal Presentation	11:15	14:15	Hub
Friday	External	Gen:External Appt.	09:45	10:15	Ward
Saturday	Nursing	Gen:CTM/Tri/CPA	09:00	15:30	Skye Centre
Sunday	AHP	OT:Walking 1-2-1	10:00	19:00	Skye Centre

Redesign of Woodwork Centre

The activity space which was previously defined as the Woodwork activity centre was cleared of the woodwork machinery/equipment and modifications were carried out by Estates and concluded in June 2018. The patient group were involved in a project which involved them painting the room floor which they carried out over 2 days. The intention for this space was for it to become a bookable activity space whereby a range of planned individual or group activities could be facilitated by a range of professionals i.e. Skye Centre, Occupational Therapy, Arts Therapy, PCIT. In order for this to progress further an SBAR was submitted to the H&S Committee and SMT with recommendations for a review of

the skill mix required to facilitate activity in this space, which was supported by both groups. The room is now an allocated bookable space which can be accessed by a variety of disciplines.

The Community Choir is a Drop in activity that was introduced in December 2018 and is co-facilitated with the Music Therapist and Skye Centre support staff. Since the Choir was introduced at the beginning of December 2018 it has been provided on 16 occasions and has on average 7 patients attending each week.

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 more detail within the recent Patient Learning 12 month Update report to the Board received in February 2019.

A range of themed learning groups were delivered within the Patient Learning Centre during the period of reporting – The topics were Dragons Den, Movie Magic and Robert Burns. The themed learning groups were used to support and facilitate core skill achievements in 'Communication' and 'Working with Others'. This group learning approach is now a regular option for patients and is delivered over a 12 week period, and patient feedback from the groups delivered was highly positive.

The Craft & Design activity centre successfully delivered two SQA National 2 Creative Arts programmes. This included one full-tooled programme and one low-tooled programme. The low-tooled programme was developed and piloted in July 2018 to increase access to learning opportunities for patients who are risk assessed as unsuitable for activity sessions involving use of tools. Initially it was thought that only 2 of the 3 units that comprise the National 2 award could be delivered within the low-tooled programme, however, due to creative problem solving by staff within the crafts department all 3 units were able to be delivered and patients participating in the low-tool programme were able to complete the full National 2 award.

In addition to delivering the National 2 Creative Arts programme, the Craft & Design centre have developed a new programme to enable delivery of the SQA National 2 Practical Crafts qualification. This new programme commenced in February 2019 for a duration of 12 weeks and the practical activities were based on pottery skills.

The Sport Leadership programme continues to be delivered within the Sports & Fitness activity centre and in 2018 the centre increased provision to facilitate delivery of 2 programmes across the year. Cohort 2 completed the programme in January 2019 with another programme due to commence in August 2019.

Sickness

The staff sickness levels across the service have increased over the past 12 months, averaging 7.91% in comparison to 4.94% reported the previous year. Long term sickness has increased from 3.71% to 5.52% and short term sickness has continued to increase slightly from 1.22% to 2.39%. The monitoring of staff sickness levels remains a focus for the Skye Centre Manager to continue to drive improvement in this area.

Events

The Skye Centre service continues to provide a series of planned 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 and the Sportsman's Dinner, recognising the patients' achievements and progress. 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 team and Person Centre Improvement Team.

Figure 16 below provides detail on the number of patients attending the range of events provided over the past 12 months.

Figure 16 - Patient Attendance at Events

Department	Description of Event	Date of Event	Number of Pt attendances
PLC	Patients Learning Event	Mar-19	38
Sports	Sports Man Dinner	Mar-19	40
Atrium	Summer event	Jun-18	27
Atrium	Summer event	Jul-18	40
Atrium	Summer event	Aug-18	29

The 'Events Committee' group, established during a TSH3030 project last year, has been introduced into the Skye Centre to offer patients across the hospital an opportunity to participate in a voluntary role, as an events committee member. Patients are encouraged to develop and employ the necessary skills and confidence to work effectively in a co-operative group setting to plan four evening social events for patients in the Skye Centre. The group promotes employability skills and motivation for participation in meaningful occupation. Pre and post volitional questionnaire evaluation tracks changes in patient volition. A new addition to the group approach this year is to offer patients the 'Working with Others' qualification if they wish to undertake this.

Outcome Measures

The creation of the Senior Occupational Therapist post in February 2019 within the Skye Centre has enhanced the assessment and treatment process available to our patients and further steps are being taken to embed this across the service. A list of the standardised assessments that have been carried out since this individual has taken up post are detailed below:

Volitional questionnaire	10 patients
OCAIRS	1 patient
MOHOST	3 patients
Interest Checklist	5 patients
Allen Cognitive Level Screen	3 patients
Peavy social comportment	2 patients

Section 5 – Identified Issues and Potential Solutions

Recruitment

Every effort has been made to ensure the vacancies that have arisen over the past 12 months are being progressed. The recruitment for these posts is ongoing and at various stages in the process. The Gardens Activity Centre had previously been unsuccessful in recruiting to the Band 5 Senior Rehabilitation Instructor post. Staffing contingencies were put in place to minimise the disruption to this service and the skills and knowledge within the existing staff group were utilised to maintain a level of

horticulture activities for our patients. The job description for the post was revised and it was re-advertised in April '19 with a successful candidate identified. This individual has a wealth of horticultural, training experience and knowledge and comes with the relevant SQA assessor qualification. There are presently 6 vacancies (5 WTE) across the service at various stages of the recruitment process. It is anticipated that the post holders for 2 of these vacancies will commence by August 2019 with remaining vacancies being filled thereafter.

Section 6 - Future Areas of Work and Potential Service Development

Vocational Activity Space

The Vocational Activity room is now available to be booked for individual or group activities by a range of disciplines. In particular the Skye Centre Leadership Group will monitor and support the use of this room to ensure that it is used to its maximum potential.

Patient Day Project

The Patient Day project has achieved an identified ward from each Hub to attend the Skye Centre for 2 sessions each week. The Patient Day Steering Group has agreed that further evaluation of the Patient Day Model will be carried out and commence in June 2019. The focus will be on the Iona 3 patient group, taking into consideration feedback from these patients and their lack of engagement in planned structured activities whilst at the Skye Centre. It has been agreed that these patients will be offered a range of activities out with the Atrium area specific to their needs and interests over the coming months after which their engagement in the process will be re-evaluated.

Patient Timetable

The format of the patient timetable has been developed and the pilot has been concluded. The Sub group are meeting in June 2019 to discuss and make the necessary changes received from the Pilot in order to implement this new system across the site.

Outcome Measures

The initial work carried out by the Senior Occupational Therapist will be embedded across the service and planned focussed work related to the completed patient interest checklists will support the future development of new and appropriate activities.

Provision of Activity out with 9 – 5

The patient group via the What Matters To You events and the PPG have requested that more activity is made available out with the business hours of 9 -5. This will be explored further in conjunction with the patient Events Group. Plans are already in place to provide summer evening activities and the potential for evening learning activity is being explored once the Patient Network is in situ by end of June 2019.

Efficiency Savings Targets

The importance of ensuring that agreed efficiency targets are achieved is also recognised. The Skye Centre service has achieved the agreed savings target last year, with £187k identified as recurring savings for the financial period 2018/19. For the financial period 2019/20 the agreed savings target is £50k. 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 2020.

Appendix 1 Skye Centre Complaints 1 June 2018 - 31 May 2019

First received	Description (Policies)
04/06/2018	Various patient's complained about the hospital shop frequently being closed at the weekend.
30/08/2018	Patient complained that they are not permitted to use the dumbbells in the gym.
26/10/2018	Patient complaining about a lack of access to sports facilities.
30/10/2018	Patient complained that about access to the hospital shop, which he cannot access the shop on the weekend because he does not have grounds access, cannot attend bingo because a patient he is disassociated with also attends, wants a new consultant within his hub.
31/01/2019	Patient complained that the persistent and continuing closures of the PLC is affecting his ability to complete his Open University coursework.
22/03/2019	Patient complained that he was not permitted to share sweets with his peer in the Skye Centre Atrium, but has been permitted to do so previously. The same staff member then proceed to open a multi pack and share crisps with staff.
24/04/2019	PAS complained on behalf of Iona 3 patients that the Patient Active Day was boring and offered nothing that they could not do on their own ward.
10/04/2019	Carer complained that his sons garden placement has been cancelled as the department is closed all week.
22/11/2018	PPG raised concerns about the lack of a hairdressing services within the Skye Centre.

First received	Description (Policies)
23/11/2018	Patient complained about the lack of access to a hairdressing service and lack of succession planning when the current hairdresser was known to be leaving to join the wards.
26/11/2018	Patient complained about the lack of access to a hairdressing service and the impact this is having on him.
23/11/2018	Patient complained about the lack of hairdressing service within the Skye Centre.
19/12/2018	Arran Patient's complained collectively about the prices in the hospital shop.

18/07/2018	Patient complaining that the shop in the Skye Centre Atrium is always closed at the weekend.
24/04/2019	Patient complained about the length of time it was taking to get a leg brace.

Outcome	Closed	Outcome code
SCN met with the patients to discuss the issues raised. She explained that currently the Skye Centre plans to open each weekend however this has frequently changed at short notice due to staffing deficits elsewhere in the hospital and the shop has been cancelled. She informed them that she would be discussing this with the Skye Centre Manager on her return from annual leave, and that every attempt will be made to increase consistent access to the Skye Centre at the weekend and apologised for the impact of the closure of the shop.	08/06/2018	Upheld
The use of dumbells was suggested by patients at the recent 'What Matters to You' event and the Sports team are exploring this possibility, which is dependant on advice given relating to the risk and security factors which need to be considered.	04/09/2018	Upheld
Patient currently has 4 sports sessions per week (2 x fitness suite, 1 x bowls and 1 x yoga. In addition has sessions at Crafts, Gardens and PLC.	05/11/2018	Not Upheld
The Skye Centre staff keep a record of who attends all activities to ensure access is fair. They are also very flexible when it comes to getting to the Skye for things like cards out with the patients shop day. RMO met with patient who confirmed that he was happy for her to remain as his RMO.	06/11/2018	Not Upheld
During January 2019 there were a possible 31 sessions that the patient could have attended. He attended 26. The reasons recorded for non-attendance were 2x fog, 1x snow, 1x searching in Arran ward closed, and 1x staffing issues.	06/02/2019	Not Upheld
Verbal response: Skye Centre Manager met with patient and advised that staff can intervene if they have a concern about patients swapping food items for the wrong reasons. However she was unaware of a reason to do so in this instance and therefore apologised to patient. Manager will address this with staff member involved.	28/03/2019	Upheld
Meeting held on ward on 30.04.19 with Skye Centre Manager, PAS, SCN, RMO ward staff and patients - to update outcome of meeting. Information leaflet reissued to all patients outlining purpose of the project. Through discussion patient/stafff were able to identify solutions to support continued involvement.	30/04/2019	Partially Upheld
Gardens closed all week as remedial building work has been taking place on the animal sheds to ensure they are fit for purpose. There was no way to facilitate safe attendance and activity for any patients while this work was being carried out. This will be completed this week and every attempt will be made to ensure that patient is supported to attend his allocated Gardens session.	11/04/2019	Upheld
Following resignation of current hairdresser the decision was taken not to advertise the existing post but to identify an external provider through SLA, ensuring a regular weekly service to patients all year round. We anticipate the new service will commence January/early February next year. A local barber, who has provided the service during periods of absence agreed to provide an interim service. Unfortunately, this did not happen as quickly as we would have hoped due to his current business commitments. However, will commence from Sunday 9 December 2018 in the Skye Centre.	06/12/2018	Upheld

Outcome	Closed	Outcome code
As above	06/12/2018	Upheld
As above	06/12/2018	Upheld
As above	06/12/2018	Upheld
The hospital shop cannot compete with the big retailers such as Tesco. However, stock items are sold at the recommended retail price (RRP), which is the same price that would be paid in local shops such as Premier and Keystore in communities all around Scotland.	21/01/2019	Not Upheld

PAS provided patient with an update from a previous response that staff were being deployed to cover the wards but Skye Centre staff were trying to ensure the shop was open on the weekends as much as possible. PAS also advised that the "Supporting Healthy Choices" group is reviewing weekend access. Patient did not feel there was any benefit from speaking to staff about this as it won't change anything.	20/07/2018	Withdrawn
Physiotherapy response good. No delay in her ordering the equipment. Equipment has taken a few weeks to arrive, which is not unusual. Equipment arrived in time for a pre-arranged appointment with the patient on 30.04.19. He now has the knee strap and is satisfied. During meeting with patient 01.05.19, he advised that he should never have made the complaint and wishes to withdraw it.	01/05/2019	Withdrawn

Appendix 2

Ward	Date	What worked well for you today?
Arran 2	24/01/2019	I like the peace and quiet and time to relax.
Arran 2	24/01/2019	Nothing in particular.
Arran 2	24/01/2019	I enjoyed getting out and letting others hear me sing.
Arran 2	24/01/2019	It's not any different than being on ward other than I get an extra coffee.
Iona 3	23/01/2019	I get to read the papers.
Iona 3	23/01/2019	Nothing particularly - come in for 10-15 minutes and go out on grounds access the rest of the time.
Iona 3	23/01/2019	Having a new routine, lets me socialise. I can take ownership of this decision and enjoy myself whilst I'm here.
Iona 3	23/01/2019	Wasn't looking forward to coming, but once here it's fine.
Iona 3	23/01/2019	Getting off the ward and sitting in a quiet area.
Iona 3	23/01/2019	Watching a movie was good.
Iona 3	23/01/2019	Communication with others. Getting to know other patients.
Iona 3	23/01/2019	Enjoyed watching a film, mixing with other patients.
Iona 3	23/01/2019	Enjoyed watching a film with staff and patients.
Lewis 2	22/01/2019	I got a drop in at PLC because some of the other patients I would have played cards or board games with weren't there.
Lewis 2	22/01/2019	I liked playing chess and cards.
Lewis 2	22/01/2019	Getting a drop in at Gardens. I've arranged to attend either Sports or Gardens on a drop in basis each Tuesday PM.
Lewis 2	05/02/2019	It was alright as I've sat and listened to music
Lewis 2	05/02/2019	Chance to get a break from the ward.
Mull 2	21/01/2019	Getting off the ward but I didn’t know what to expect.
Mull 2	21/01/2019	Getting out of the ward.
Mull 2	21/01/2019	Nothing.
Mull 2	21/01/2019	I enjoyed the peace and quiet. It was good to talk to patients from other wards. I was able to read my book.
Mull 2	25/01/2019	Like to get off ward - not too bothered about going to a placement - it's shop day too.
Mull 2	25/01/2019	We can go back. Socialise a bit first.

Mull 2	25/01/2019	Today has been not too bad. Feeling better now as I'm on new medication which is starting to kick in now and I'm not so anxious and panicky.
Mull 2	25/01/2019	Shop day so all is good. Happy to sit and chat.
Mull 2	25/01/2019	It was ok (patient difficult to engage with. Other patient also tried to engage with limited success).
Mull 2	25/01/2019	Like being here, better than on the ward
Mull 2	28/01/2019	Playing Xbox and 10 pin bowling.
Mull 2	28/01/2019	Having a chat with patients and staff.
Mull 2	28/01/2019	Not much.

Anything you found difficult today?	If we could make one change to improve your experience, what would it be?
I'm quite happy as I am.	
I would prefer to stay on the ward. I don't like the Hospital never mind the Skye Centre.	I don't like taking part in organised activites. I prefer to be on my own.
Not really.	Events planning teams for each ward that takes part like Arran's TSH 3030 Events Team.
Just being bored.	Having staff available to take part in activities. **Scrabble, cards**, walks and **film shows**.
It's boring.	Open the shop.
Nothing.	I would prefer if Iona were up here in the mornings and afternoons on different days.
I had to tell the nursing staff about an incident today and that was a little difficult.	Snacks available to purchase via the Atrium Café.
The amount of people in the area.	More teas and coffees - only 2 allowed.
Nothing, it's ok.	It would be good to have a TV for me to **listen to music** in the quiet corner of the Atrium.
Nothing. I'm quite happy to sit and relax.	I like to **listen to music**, **watch films** and play **board games**, it would be good to get new ones to play.
A wee bit too long a time.	Quite happy the way things are. I like to have a few activities to choose from so that's good.
No difficulties today.	Happy with the service so far.
At some points I was struggling with so many patients and staff in the Atrium.	Some more up to date **movies.**
Enjoyed being here. Quite happy with what is on offer.	
Nothing.	More people to play **chess** with would be good.
Nothing.	Possibly make use of the Vocational Room for organised activity.
Nothing. There are plenty of activities available if I want them.	
	Getting grounds access would give me more options.
Feeling anxious all morning being here.	I would be happy to give any activity a try.
A bit bored - nothing to do.	I would prefer a placement at any other area rather than being in the Atrium.
I would rather be on the ward watching TV as I feel at home there. Too busy for me with PLC & Sports coming to the Atrium for coffee.	I would probably come up for a coffee and then go out for a walk.
They should have board games and bingo for us, it can be quite boring.	
Nothing - it's ok here.	
Good atmosphere, I enjoy it.	Pool table like the one in the Hubs.

Was hoping to go to Yoga but not on today (back on next week).	Activities should be right for how well you are. I don't want to be in a busy place and having to talk to folk all the time.
Sports closed so couldn't have a session.	Open all the areas so we are not just sitting about.
Nothing really, shop day so expected to be here anyway.	
No sessions to go to. Going to try and go to Crafts next week.	
Nothing. I'm quite happy with what is on offer.	
Nothing. Lots of games out, Xbox available too.	
I'm very anxious, there are far too many people in the Atrium. Not done Skye Centre induction, not sure I would like a placement as I've never been in any of the departments.	

Appendix 2 Patient Day Project - Data

Month 2019	Number of patient attendances at Patient Day Project	Number of attendances at planned Activity sessions	Number of patients who remained on Hub	Number of patient attendance at OT/PTS Service	Number of Ward staff in attendance	Number of occasions the ward closed	Comments
Jan-19							
Arran	45	37	4	10	19	3	
Iona	47	17	8	0	16	0	
Lewis	19	41	10	2	11	0	
Mull	24	33	13	0	13	2	Ward did not attend on one occasion due to inclement weather
Feb-19							
Arran	46	46	0	4	11	8	
Iona	60	16	18	2	10	6	
Lewis	44	39	12	1	16	5	
Mull	38	40	4	0	27	7	
Mar-19							
Arran	49	46	1	3	21	1	
Iona	60	45	16	1	15	4	Project late in starting on 1 occasion, no data on staff numbers on 1 occasion. 1x staff sent to Arran due to clinical activity
Lewis	33	34	16	1	14	1	No data available on one occasion
Mull	40	39	6	1	23	0	
Apr-19							
Arran	65	29	0	0	21	6	1x PH (Skye Centre reduced service).
Iona	45	19	14	0	10	3	1x Ward did not attend due to incident. No data on staff on one occasion
Lewis	22	20	6	2	8	2	No data available on two occasion
Mull	26	33	3	0	22	0	1xPH (Skye Centre reduced service) and no data available x1 occasion

THE STATE HOSPITALS BOARD FOR SCOTLAND

Minutes of the Clinical Governance Committee Meeting held on Thursday 9 May 2019 at 9.45am in the boardroom, The State Hospital, Carstairs.

CHAIR:	
Non Executive Director	Nicholas Johnston
PRESENT:	
Non Executive Director	David McConnell
Non Executive Director	Maire Whitehead
IN ATTENDANCE:	
Board Chair	Terry Currie
Chief Executive	Gary Jenkins
Chair of Medical Advisory Committee	Khuram Khan
Head of Corporate Planning and Business Support	Monica Merson
Research and Development Manager	Jamie Pitcairn [Item 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 received from Mr John Marshall and Mr Robin McNaught.

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 14 February 2019 were approved as an accurate record.

APPROVED

4 PROGRESS ON ACTION NOTES

The Committee noted progress on the Minute Action Points from the last meeting.

The Committee received an update from Ms Merson on relation to Action No. 3 – on benchmarking the reporting process around the approval of Category 1 and 2 reports within other NNS Scotland

Boards. This indicated some variance form the current measurement for reporting at The State Hospital (TSH) and similarity in terms of some the difficulties experienced in completing reporting. At TSH the main difficulties were staff absences delaying the investigation period, as well as the internal approval reporting process for the finalised report. Mr Jenkins added that a 12-week target for concluding investigation was good practice to ensure timeous progress on any actions to ensure mitigation against any repeat incidents.

Committee Members noted that the reporting process was not their key concern in this forum – and the process would be reviewed operationally. However, the concern for the Committee was for meaningful reporting for this forum highlighting any potential areas of concern, and progress in the actions taken in response. It was agreed that a traffic light style of progress reporting should come back to the Committee to provide assurance in this area.

Action – Ms Merson

Members also discussed the delay experienced in completing investigations due to staff availability and this was noted as an area to remit to the Staff Governance Committee.

Action – Ms M Smith

The Committee also received an update on Action No. 4 from Ms Merson on the Category 1 investigation report 18.01 which focused on the review of recommended changes to the physical site. A further update would be brought to the next meeting of the Committee with an invitation made to the Director of Security, Estates and Facilities to attend.

Action – Ms M Smith

NOTED

5 MATTERS ARISING

There were no further matters arising.

NOTED

6 INFECTION CONTROL – 12 MONTHLY REPORT

A report was received from the Director of Nursing and AHPs which outlined the range of infection control activity undertaken at TSH and summarised the work undertaken by the infection control service. Mr Richards summarised the key points of the report for members highlighting areas of good practice and that there had been no significant areas of concern. He also provided assurance to the Committee that TSH had complied with reporting to Scottish Government following the Queen Elizabeth University Hospital (QEUH) report from Healthcare Environment Inspectorate (HEI) and that no areas of concern had been found within TSH.

The Committee noted two areas of concern: hand hygiene within the Skye Centre and SIPSEP training compliance had decreased over the past 12 months. The Committee asked for specific assurance from the Infection Control Committee on these two points.

Mr Richards provided some feedback on the positioning of hand hygiene gel dispensers within the Skye Centre and that moving these to a more prominent position had raised some security concerns. He confirmed that the feedback from this Committee would be fed back to the Infection control Committee as part of their remit to take forward and resolve.

Action – Mr Richards

Members also discussed staff take up of the flu vaccination in terms of how this is offered to staff.

Mr Richards outlined the mixed delivery methods in place which included at ward level to ensure staff had every opportunity to be vaccinated. Professor Thomson highlighted that all patients were encouraged to receive the vaccination.

The Committee requested that the Chair of the Infection Control Committee write to the Board Chair and CEO to confirm the TSH response to Scottish Government following the HEI report on QEUH –including a copy of the TSH plan. An update would be brought back to the next meeting of this Committee.

Action – Mr Richards

NOTED

7 RESEARCH COMMITTEE/ RESEARCH GOVERNANCE AND FUNDING 12 MONTHLY REPORT

A paper was submitted by the Medial Director, which outlined the range of research activity undertaken within TSH as well as the implementation of research findings into practice. The report also provided an update on the Research and Clinical effectiveness as well as the Forensic Network Research conference.

Mr Pitcairn was in attendance to lead Members through the report and highlighted the way in which the report specifically addressed additional ways to monitor performance and the progress made against actions outlined within the Research Strategy 2016 -2020.

Members asked for assurance on factors affecting the use of the research budget and Mr Pitcairn advised that the sometimes challenging staffing position particularly within nursing meant that it could be difficult to recruit staff into research assistant roles. In answer to a further query on any yearly underspend, Mr Pitcairn clarified that these funds remain within part of budget with no detriment to the following year's budget. His role was to utilise the budget effectively within the stated aim of improving clinical practice.

A further point raised was on difficulty in recruiting patients as participants and Mr Pitcairn acknowledged that this could be the case especially for single site studies. Professor Thomson advised that although this was being addressed through the Forensic Network, differing practices across sites could be problematic. Mr Pitcairn added that other forensic sites did not have a dedicated research function.

The Committee noted and approved the report. The work carried out on research study implementation as well as to include patients' voices was noted as areas of good practice.

APPROVED

8 FITNESS TO PRACTICE

A report was submitted to the Committee to outline the process for monitoring professional registration status at TSH – and give assurance to the Committee that staff members hold current professional; registration. This report provided assurance specifically on NMC registration for nursing staff rather than a separate report being required to be submitted to the Board.

It was proposed that further reporting would include social work and pharmacy staff (albeit that these staff groups were not directly employed by TSH).

The report was noted to be flagged as of interest to the Staff Governance Committee

Action – Ms M Smith

NOTED

9 PATIENT MOVEMENT – STATISTICAL REPORT

A report was submitted to the Committee, by the Medical Director, as an overview of activity across admissions, discharges and transfers in the hospital at 31 March 2019.

In response to a query raised, Professor Thomson clarified the legal process prior to admission, meaning that there may be a time lapse for this reason between referral and admission. In respect of the transfer list, it was noted that there was pressure experienced within the forensic estate.

NOTED

10 DUTY OF CANDOUR ANNUAL REPORT

A report was submitted by the Head of Corporate Planning and Business Support, and Ms Merson led Members through a summary of the report.

The Committee were content to note the report, and the rigorous work undertaken within the organisation.

NOTED

11 LEARNING FROM COMPLAINTS AND FEEDBACK - QUARTER 4 REPORT

A report was submitted to the Committee which provided an overview of activity of complaints and feedback for the fourth quarter of the current financial year.

Ms Merson summarised the key points for the Committee in relation to complaints. It was noted that trend reporting would be a helpful addition to the report and Ms S Smith advised that this would be included in annual reporting.

Mr Richards provided a summary of the learning from feedback, and Members were content to note this update. The feedback on the Sportsmen's dinner and the Patient Achievement Awards was noted – attendance at these type of events by senior managers and medical staff as well as Board Members should be encouraged. This as noted as part of the Corporate Governance Blueprint report for the Board. Co-ordination of diaries for these events would assists and this should be noted to the relevant event organisers.

Action – Ms M Smith

It was agreed that for future reporting, two reports would be brought to the Committee on each area i.e. complaints and feedback, members underlined the importance of a continued focus on organisational learning overall.

Action – Ms Merson/Mr Richards

NOTED

12 INCIDENTS AND PATIENT RESTRICTIONS

A report was submitted to the Committee, on behalf of the Medical Director, which provided an overview of activity of incidents and patient restrictions within the fourth quarter of the current financial year. Professor Thomson led Members through the detail of the report.

Members discussed the presentation of data, particularly around trend analysis and narrative context

and agreed it would be helpful for the report to be revised going forward with focus on an assessment and summary of findings.

.

Action - Ms Merson

NOTED

13 CLINICAL GOVERNANCE STOCKTAKE

A report was received from the Medical Director, which outlined the wide range of activity overseen by the Committee during 2018 /19. This also included the Committee's Terms of Reference Reporting Structures and Work Programme.

Members considered the content and were content to approve the report as a good summary of the Committee's work especially around areas of good practice and evidencing consideration of areas of concern.

APPROVED

14 CLINICAL MODEL - UPDATE

The Committee received a verbal update from Ms Merson on the progress to date on the review of the clinical service delivery model, highlighting staff engagement underway and the planned move toward options appraisal through benefits criteria. Two further workshops were planned to take place to take forward this process with the focus being on an inclusive approach.

This update followed the update to the Board at its meeting on 25 April 2019. Mr Jenkins added that it was helpful to take stock of the process to date and take forward a wider concept of what the model would address, as well as sub-themes which had arisen through the engagement process and which would require a wider system change approach. There should be a focussed approach to the financial model underpinning any change. A project approach to encompass all of this would be effective in doing so in a credible way and must be with reference to the organisation's financial outlook.

Members were in agreement with this approach, and discussed the risk of any mission drift, from the original focus on patient well-being. At the same time Members underlined the importance of the feedback from staff around staff safety and perceived need for change within the clinical service delivery model.

It was agreed that this would be scheduled as the discussion item for this Committee at its August meeting.

Professor Thomson/ Mr Richards/ Ms Merson

NOTED

15 CATEGORY 1 REVIEW – 18.02

The Committee reviewed and considered this report. Mr Richards provided Members with an overview of the report findings.

The breach of confidentiality for patients was emphasised in the discussion that followed – that as the breach came from a member of staff and that had very serious consequences for trust from patients.

Mr Richards also confirmed the action taken in referring this matter to Police Scotland given that breached of GDPR represented a criminal offense, as well as liaison with the Information

Commissioners Office (UK). He would circulate background information in terms of the legal position to Committee Members.

Action – Mr Richards

Members agreed with the approach outlined – that it was essential for the Board to consider the legal position and what action could be taken to protect confidentiality of both patients and staff.

Members requested that consideration be given to a less heavily redacted version of this type of report be made available for discussion in future if possible.

Action - Ms Merson

NOTED

16 AREAS OF GOOD PRACTICE / AREAS OF CONCERN

The Research Committee report was noted as an area of good practice with reference to research study implementation as well as inclusion of patient feedback.

An area of concern was highlighted for the Infection Control Committee in terms of hand hygiene in the Skye Centre and the downward trend of completion of SIPSEP learning modules.

17 WORKPLAN

It was agreed that the clinical service delivery model should be the discussion item for the August meeting.

18 ANY OTHER BUSINESS

The following were noted as items from this meeting to be shared with the Staff Governance Committee:

- Risk – Category 1 and 2 investigations – delay due to staff absence.
- Fitness to Practice report

19 DATE AND TIME OF NEXT MEETING

The next meeting would take place on Thursday 15 August 2019 at 9.45am in the Boardroom, The State Hospital, Carstairs.

The meeting concluded at 12.15pm

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	20 June 2019
Agenda Reference:	Item: 11
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 2019
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 2018/19. 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 2018/19, 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

Members of the Board are asked to note and agree the Staff Governance Committee Annual Report.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	N/A
Workforce Implications	N/A
Financial Implications	N/A
Route To Board Which groups were involved in contributing to the paper and recommendations.	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
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One √ There are no privacy implications. □ There are privacy implications, but full DPIA not needed □ There are privacy implications , full DPIA included.

THE STATE HOSPITALS BOARD FOR SCOTLAND

STAFF GOVERNANCE ANNUAL REPORT

1 April 2018 – 31 March 2019

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:

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- 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 2018/19, 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 2018/19 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 (part) (lay member, Prison Officers' Association)
Tom Hair (lay member, UNISON)
Brian Paterson (Clinical Operations Manager)

Ex-officio members:
Terry Currie (Chairman)
Jim Crichton (Chief Executive)
John White / Kay Sandilands (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 2018/19

During 2018/19 the Staff Governance Committee met on 5 occasions, in line with its terms of reference (Appendix 1). Meetings were held on:

5 April 2018
31 May 2018
16 August 2018
29 November 2018
7 February 2019

4. REPORTS CONSIDERED BY THE COMMITTEE DURING THE YEAR

The Committee received reports and monitored areas as follows:

- Staff Governance Standard National Annual Monitoring Return 2017/18
- Monitoring of PDPR, Personal Development Plan Reporting performance
- Annual Submission to Scottish Government of mandatory workforce statistics.
- Monitoring of Attendance Management performance
- Monitoring HR Performance – Employee Relations Activity
- 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 2017/18

The Staff Governance Action Plan return for 2017/18 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:

- The evidence provided highlights a number of actions that the Board has taken to inform continuous improvement across all 5 strands of the Standard
- The range of measures in place to ensure a better use of the TURAS Appraisal System, which will hopefully see an improvement from the activity recorded on eKSF.
- Partnership working is considered a priority within TSH and a fundamental component of your plan to deliver Safe, Effective Patient Care.
- NHS State Hospitals Board for Scotland continues to have a full suite of PIN Policies in place and that all are fully PIN compliant.

Everyone Matters: 2020 Workforce Vision Implementation Plan for 2018/20

Everyone Matters: 2020 Workforce Vision Implementation Plan for 2018/20 required NHS Boards to deliver on a series of priorities and to embed the NHSScotland shared values. The overall focus of the plan is based on five priority areas with a particular focus during 2018/20 on:

- Embedding iMatter as a continuous improvement tool to improve staff experience and particularly responding to feedback, improving leadership visibility and staff engagement.
- Taking action to promote health, wellbeing and resilience.
- Working across organisational and professional boundaries to share good practice in learning and development, evidence-informed practice and organisational development.
- With our partners, developing workforce planning capacity and capability in the integrated setting.
- Delivering actions within the overview paper "Executive Level Leadership and Talent Management in the NHS in Scotland" (pub May 2017).

To take these actions forward during 2018/19:

- The Values and Behaviours group continued to meet regularly. The focus for 2018/19 has been on embedding the NHS/organisational values. This has been supported by an organisational conversation over several months and plans to develop a staff recognition framework. Work has also been delivered to improve staff engagement and to support a healthy work-life balance. ***(Healthy Organisational Culture)***

- The Transition Group, Sustainability & Transformation Group, HR and Healthy Working Lives continued to support the organisation through a challenging period. A review of care delivery and staff rostering/shift arrangements is taking place to support this agenda. ***(Sustainable Workforce)***

- The focus has been on working across boundaries, sharing learning and good practice. This has been achieved through the annual learning plan underpinned by OD, investment in our PDP process and Turas appraisal system as well as encouraging a collegiate approach to learning through initiatives like Greatix, staff recognition and TSH 30:30. ***(Capable Workforce)***

- National work around more effective collaboration between national and regional NHS Boards is fully supported by The State Hospital. Collaborative working with the other national boards to develop joined-up approaches continues in a number of key areas e.g. leadership development, OD plan, HR, procurement. The organisation already works closely with other boards to deliver some essential services e.g. primary care and social work. ***(Workforce to deliver integrated services)***

- Leadership development is supported at all levels across the organisation, with a particular emphasis in the past year on more senior leaders e.g. Project Lift, 'New Horizons' programme, SCN development programme, new executive level appraisal documentation, Board Assessment Tool and 360 degree appraisal. ***(Effective leadership and management)***

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 2018 meeting.

4.2 Progress Updates

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

- PDPR, Personal Development Plan
- Attendance Management
- HR Performance – Employee Relations Activity

The Committee had a particular focus on the performance of the organisation in relation to attendance management. Additional updates were requested by members relating to the Attendance Management Improvement Working Group that was re-convened in summer 2018. This group had three main areas of focus: Leadership, Training and Support, Policy Compliance. The target for the Task Group within their Terms of Reference was to achieve a 3% reduction (6.8% absence level) by 31 March 2019 - the level achieved in March 2019 was 6.34%.

PDPR, Personal Development Plan

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 and Partnership Forum. The average monthly completion rate was 71.6%.

Attendance Management

The State Hospitals Board for Scotland did not achieve the absence management standard of 5% in 2018/19. The end of year average absence percentage was 8.52%.
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 by closely monitoring the action plan identified within the Attendance Management Improvement Working Group.

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.

Everyone Matters: 2020 Workforce Vision

The implementation plan for 2020 workforce vision generated much debate, and informed the planning process for the Staff Governance Action plan 2018/19.
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);

Values and Behaviours Group

Work continued to progress and promote the four core NHSScotland values over the year with staff. It was agreed the core values would play a prominent part in the induction process for new members of staff. Senior Managers increased their visability across the organisation in a view to support the key messages from the organsiation's values.

Health Working Lives Group - HWL

Work continues with this group through the dedicated members of its multi-disciplinary working group. Numerous events and initiatives across the organisation are supported and delivered. The HWL Group provides a forum where health, safety and wellbeing issues are identified and strategies are put in place to create improvements.

The focus for 2019-20 is to continue with the ongoing work focussing on supporting mental health awareness and education, improving physical health and promoting links/networking within and outside the organisation.

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 2018/19 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 2018/19**.**

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.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	20 June 2019
Agenda Reference:	Item: 12
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 2019
Purpose of Report:	For approval

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 2018/19. 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

Members of the Board are asked to note and agree the Remuneration Committee Annual Report.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	N/A
Workforce Implications	N/A
Financial Implications	N/A
Route To BOARD Which groups were involved in contributing to the paper and recommendations.	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
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	N/A
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One √ There are no privacy implications. □ There are privacy implications, but full DPIA not needed □ There are privacy implications , full DPIA included.

THE STATE HOSPITALS BOARD FOR SCOTLAND

REMUNERATION COMMITTEE ANNUAL REPORT

1 April 2018 – 31 March 2019

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 2018/19, 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

Ex-officio members:
Jim Crichton, Chief Executive
John White, Interim HR Director (part year)
Kay Sandilands, Interim HR Director (part year)
Margaret Smith, Board Secretary

3 MEETINGS DURING 2018/19

During 2018/19 the Remuneration Committee met on three occasions, in line with its terms of reference. Meetings were held on:

- 28 June 2018
- 25 October 2018
- 28 February 2019

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 2017-18.

- 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 2018/19.
- Consultants discretionary points were reported on and approved.
- Endorsement of new post grading by National Evaluation Committee new Senior Management appointments.

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 2018/19.

THE STATE HOSPITALS BOARD FOR SCOTLAND

REMUNERATION COMMITTEE

TERMS OF REFERENCE

TITLE

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

COMPOSITION

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

- The Committee Chair
- The Chair of The State Hospitals Board for Scotland
- All other Non-Executive Directors of the Board, including the Employee Director

In addition there will be in attendance:

- Chief Executive
- Human Resources Director
- Board Secretary

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

3 The Human Resources Director will be the Executive Director Lead and will attend meetings of the Remuneration Committee as Advisor and to provide administrative support.

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

- support the Chair in ensuring that the Committee Remit is based on the latest guidance and relevant legislation;
- liaise with the Chair in agreeing a programme of meetings for the business year, as required by its remit;
- oversee the development of an Annual Workplan for the Committee which is congruent with its remit and the need to provide appropriate assurance at the year-end, for endorsement by the Committee and approval by the Board;
- agree with the Chair an agenda for each meeting, having regard to the Committee's Remit and Workplan;
- oversee the production of an Annual Report, informed by self assessment of performance against the Remuneration Committee Self Assessment Handbook, on the delivery of the Committee's Remit and Workplan for endorsement by the Committee and submission to the Board.

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

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

FUNCTIONS

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

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

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

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

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

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

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

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

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

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

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

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

CONDUCT OF BUSINESS

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

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

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

REGULARITY OF MEETINGS

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

REPORTING ARRANGEMENTS

19 The Remuneration Committee will report to the Board.

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

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

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

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

21 A Report, marked as ‘confidential’, on each meeting of the Remuneration Committee will be issued to the Non Executive Directors of the Board.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	20 June 2019
Agenda Reference:	Item: 14
Sponsoring Director:	Interim Human Resources Director
Author(s):	Interim Human Resources Director
Title of Report:	Attendance Management Report
Purpose of Report:	For noting

1 SITUATION

The State Hospital (TSH) sickness absence level in-month figure for March 2019 was 6.34%; with an average rolling 12 month figure of 8.26% for 2018/19.

This is the second lowest monthly level of absence in TSH in the last 12 months and the annual figure is 0.24% lower than the 2017/18 level.

However, absence still exceed the 5% target level.

2 BACKGROUND

Over the last 3years, TSH monthly absence levels have frequently been between 8% and 10%. Consequently absence management and monitoring have been areas of particular focus.

Absence data reported is extracted from both the SWISS, the national source and SSTS local information system to provide this report.

3 ANALYSIS

The March 2019 sickness level of 6.34% is the second lowest in-month level recorded by TSH in 2018/19 and the lowest March figure in 5 years (Appendix III). However, this does exceed the 5.0% target and the NHS Scotland level of 5.23% for the same period (Appendix IV).

Long/short term absence split is 3.34% and 3.00% respectively – with the long term absence level falling successively in the last 4 months from 5.69% (Appendix II).

The in-month absence level equates to a loss of 5,844.59 hours / 35.91 WTE.

The current average rolling 12 month sickness figure is 8.26% for the period 1 April 2018 to 31 March 2019. The long/short term split is 6.40% and 1.86% respectively. This represents a lower figure than both previous years (2017/18 – 8.5%, 2016/17 - 8.35%) and an in year reduction of 0.26%. The recent NHS circular

(PCS(AFC)2019/2) proposes Boards work towards achieving a 0.5% reduction in sickness absence per annum over 3 years.

The main reasons for absence continue to be Anxiety/Stress/ Depression/Other Psychiatric Disorders (35%), Musculoskeletal (13%) and Fractures (12%) (Appendix I).

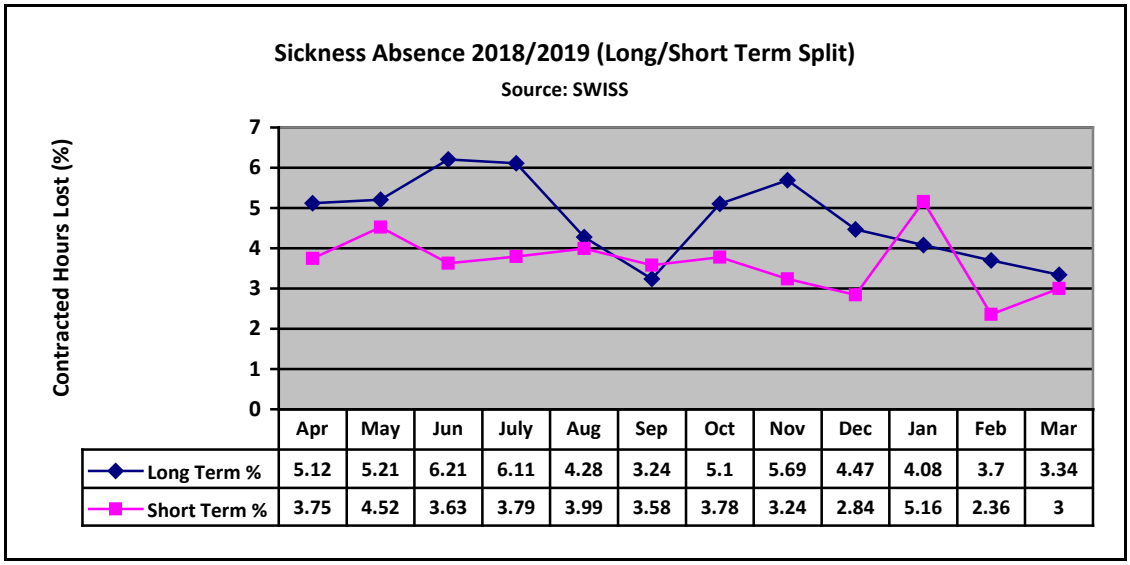
4 RECOMMENDATION

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

Appendix I : Absence Reasons 1st April 2018 to 31st March 2019

Absence Reason Description (1 April 2018 to 31 March 2019) Source: SSTS	Total (inc Industrial Injury)
Anxiety/stress/depression/other psychiatric illnesses	35.37 %
Other musculoskeletal problems	12.97 %
Injury, fracture	12.17 %
Gastro-intestinal problems	6.10 %
Back problems	5.38 %
Other known causes - not otherwise classified	5.05 %
Genitourinary & gynaecological disorders - exclude pregnancy related disorders	4.79 %
Cold, cough, flu - influenza	4.61 %
Heart, cardiac & circulatory problems	2.88 %

Appendix II : LONG / SHORT TERM ABSENCE BREAKDOWN – NATIONAL DATA (SWISS)

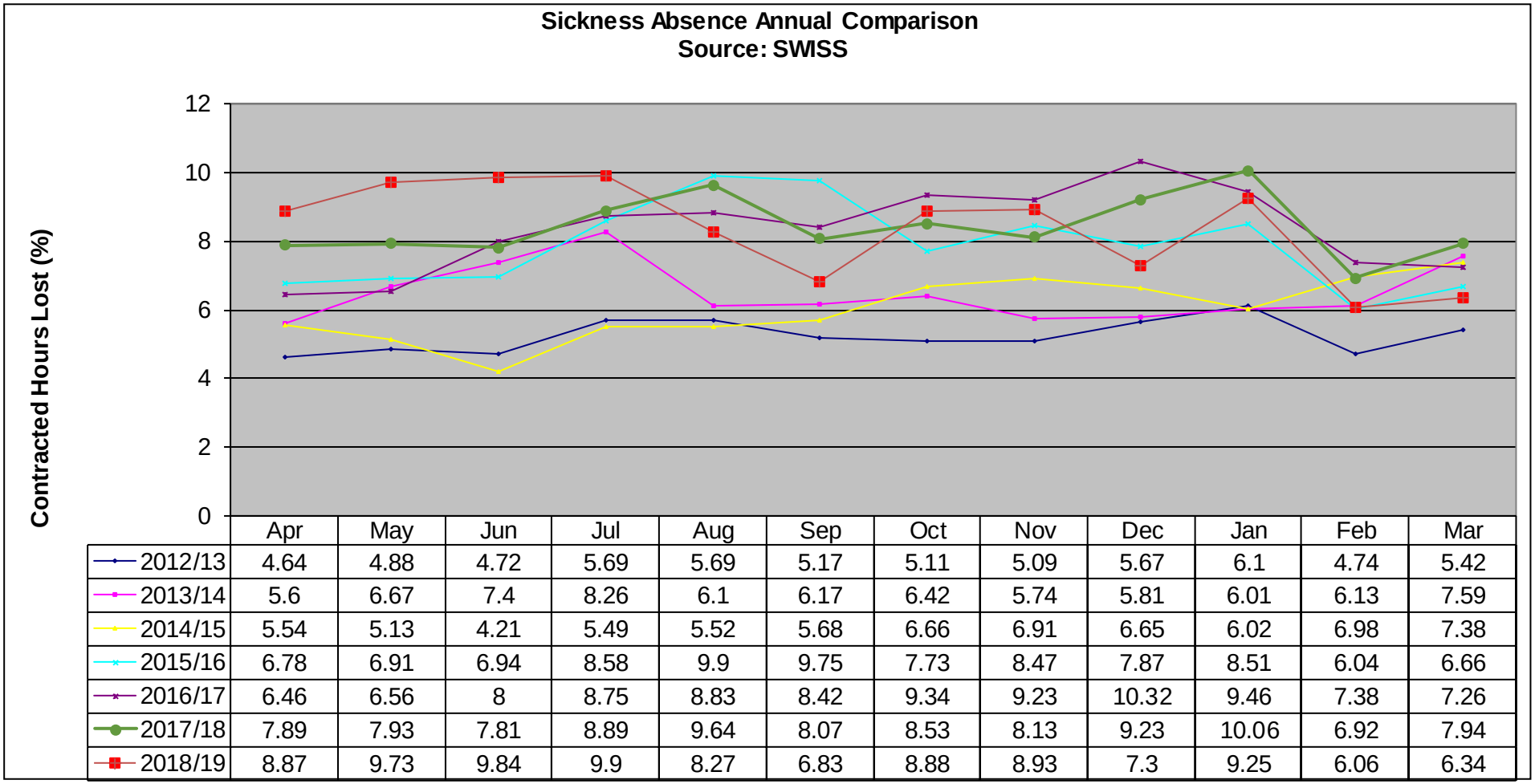


	Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Long Term %	5.12	5.21	6.21	6.11	4.28	3.24	5.1	5.69	4.47	4.08	3.7	3.34
Short Term %	3.75	4.52	3.63	3.79	3.99	3.58	3.78	3.24	2.84	5.16	2.36	3

Provides a rolling monthly comparison of long and short-term absence from SWISS for the State Hospital only.

Appendix III : YEARLY AND MONTHLY COMPARISON - details the breakdown in percentage of sickness absence for the financial years 2012/13, 2013/14, 2014/15, 2015/16, 2016/17, 2017/18, 2018/19. This data is derived from SWISS.

In the previous 12 months absence peaked during July 2019 at 9.9%.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2012/13	4.64	4.88	4.72	5.69	5.69	5.17	5.11	5.09	5.67	6.1	4.74	5.42
2013/14	5.6	6.67	7.4	8.26	6.1	6.17	6.42	5.74	5.81	6.01	6.13	7.59
2014/15	5.54	5.13	4.21	5.49	5.52	5.68	6.66	6.91	6.65	6.02	6.98	7.38
2015/16	6.78	6.91	6.94	8.58	9.9	9.75	7.73	8.47	7.87	8.51	6.04	6.66
2016/17	6.46	6.56	8	8.75	8.83	8.42	9.34	9.23	10.32	9.46	7.38	7.26
2017/18	7.89	7.93	7.81	8.89	9.64	8.07	8.53	8.13	9.23	10.06	6.92	7.94
2018/19	8.87	9.73	9.84	9.9	8.27	6.83	8.88	8.93	7.3	9.25	6.06	6.34

Appendix IV : National Comparison with NHS Scotland and The State Hospital - March 2019

	Absence Rate			Instances			Absence Reason	
	Total	Long Term [1]	Short Term [2]	Total	Long Term [1]	Short Term [2]	Yes	No [3]
Scotland	**5.23**	**2.47**	**2.76**	**26,058**	**4,315**	**21,743**	**22,349**	**3,709**
NHS Ayrshire & Arran	4.92	2.33	2.59	1,553	251	1,302	1,399	154
NHS Borders	4.46	1.69	2.77	482	59	423	416	66
NHS National Services Scotland	4.55	2.16	2.39	498	80	418	480	18
NHS 24	8.34	3.91	4.44	455	68	387	365	90
NHS Education For Scotland	1.54	0.55	0.99	83	8	75	56	27
NHS Healthcare Improvement Scotland	3.80	2.19	1.62	59	9	50	52	7
NHS Health Scotland	3.69	1.29	2.40	48	5	43	36	12
Scottish Ambulance Service	7.79	4.56	3.23	801	211	590	765	36
The State Hospital	6.34	3.34	3.00	98	26	72	94	4
National Waiting Times Centre	4.48	1.80	2.68	276	39	237	238	38
NHS Fife	5.56	2.83	2.73	1,255	257	998	1,146	109
NHS Greater Glasgow & Clyde	5.59	2.71	2.88	6,515	1,209	5,306	5,681	834
NHS Highland	5.10	2.48	2.62	1,627	245	1,382	1,068	559
NHS Lanarkshire	5.52	2.92	2.60	1,754	373	1,381	1,501	253
NHS Grampian	4.43	1.85	2.59	2,464	312	2,152	1,871	593
NHS Orkney	4.64	2.15	2.49	110	14	96	105	5
NHS Lothian	4.74	2.02	2.72	4,038	529	3,509	3,577	461
NHS Tayside	5.26	2.49	2.78	1,985	320	1,665	1,691	294
NHS Forth Valley	6.06	2.82	3.24	992	183	809	927	65
NHS Western Isles	5.01	1.94	3.08	178	23	155	159	19
NHS Dumfries & Galloway	4.59	1.75	2.84	678	85	593	621	57
NHS Shetland	3.73	1.22	2.51	109	9	100	101	8

MONITORING FORM

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

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	20 June 2019
Agenda Reference:	Item: 16
Sponsoring Director:	Director of Finance & Performance Management
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
- Update Terms of Reference

An effective system of internal control is fundamental to securing sound financial management of the Board's affairs.

The consideration and review of internal and external audit reports, and management responses, together with reports submitted by other officers, assist the Committee in advising the Board with regard to material risks.

3 ASSESSMENT

This report is presented in draft for approval to present to this afternoon's Board Meeting.

4 RECOMMENDATION

The Committee is asked to approve the Audit Committee Annual Report for 2018/19.

MONITORING FORM

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

THE STATE HOSPITALS BOARD FOR SCOTLAND

AUDIT COMMITTEE ANNUAL REPORT

1 April 2018 – 31 March 2019

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 / D McConnell (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 5 times during 2018/19.

3 AUDIT

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

The Internal Audit service was provided by RSM UK.

4 REVIEW OF THE WORK OF THE COMMITTEE

The Internal Audit Operational Plan from RSM for 2018/19 was approved by the Committee at its meeting on 28 June 2018. 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 2018/19, the Committee met on FIVE occasions: 26 April 2018, 28 June 2018, 13 September 2018, 24 January 2019 and 28 March 2019

During the period from 31 March 2018 and up to the consideration of the Annual Financial Statements on 20 June 2019, 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 2018/19 from the Chief Internal Auditor.
- Received the Annual Report and audit certificate for the 2018/19 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 2017/18 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 2019

5 CORPORATE GOVERNANCE

During 2018/19 the Board's Internal Auditors reported on the following significant areas of work:

- Effective Rostering & Overtime Management Review
- Report on Sickness and Absence Management
- Patient Activity
- Follow up of previous recommendations

6 CONCLUSION

Based on the work that it has undertaken, the Committee has met in line with the Terms of Reference, has fulfilled its remit and is satisfied that internal controls are adequate to ensure that the Board can achieve the policies, aims and objectives set by Scottish Ministers, to safeguard public funds and assets available to the Board, and to manage resources efficiently, effectively and economically.

D McConnell
AUDIT COMMITTEE CHAIR
On behalf of the State Hospitals Board for Scotland Audit Committee
20 June 2019

AUDIT COMMITTEE

TERMS OF REFERENCE

1 PURPOSE

The Audit Committee is a standing committee of the Board and shall be accountable to the Board. Its purpose is to provide the Board with assurance in respect of risk, governance and internal control including financial control.

2 COMPOSITION

2.1 Membership

The Audit 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. Membership will be reviewed annually and disclosed in the Annual Report.

2.2 Appointment of Chairperson

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

2.3 Attendance

Executive Directors of the Board are not eligible for membership of the Committee. The Accountable Officer (Chief Executive), Finance and Performance Management Director, Chief Internal Auditor, a representative from External Audit and any other appropriate officials shall normally attend meetings and receive all relevant papers. Other Directors may also be invited by the Chair of the Committee to attend meetings as required.

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

Audit Committee members must regularly attend the Committee and if not appropriate action taken.

3 MEETINGS

3.1 Frequency

The Audit Committee will meet at least four times a year to fulfil its remit and shall report to the Board at least twice in each financial year.

The Chair of the Committee may convene additional meetings as necessary.

The accountable officer should attend all meetings but if he/she does not, be provided with a record of the discussions.

The Accountable Officer of the Board may ask the Chair of the Committee to convene further meetings to discuss particular issues on which they want the Committee's advice.

3.2 Agenda and Papers

The agenda and supporting papers will be sent out at least 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.

3.3 Quorum

Two members of the Committee will constitute a quorum.

3.4 Minutes

Formal minutes will be kept of the proceedings and submitted for approval at the next Audit Committee meeting, prior to submission to the Board.

Recognising the issue of relative timing and scheduling of meetings, minutes of the Audit Committee may be presented in draft form to the next available Board meeting.

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

4 OTHER

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

If necessary, meetings of the Committee shall be convened and attended exclusively by members of the Committee and / or the External Auditor or Internal Auditor. It is expected that this should occur at least once in each financial year.

The Chief Internal Auditor and the representative(s) of External Audit will have free and confidential access to the Chair of the Committee.

The Chair of the Audit Committee should be available at the Board's Annual Accounts Approval Meeting to answer questions about its work.

5 REMIT

5.1 Objectives

The main objectives of the Audit Committee are to provide the Board with the assurance that the State Hospital acts within the law, regulations and code of conduct applicable to it, and that an effective system of internal control is maintained.

The committee periodically assesses its own effectiveness to ensure that the Audit Committee fulfils its remit, this may involve assessing the attendance and performance of each member.

New members receive a suitable induction and declare his/ her business interests.

The duties of the Audit Committee are in accordance with the Audit Committee Handbook, July 2008. http://www.scotland.gov.uk/Publications/2008/08/08140346/

5.2 Internal Control and Corporate Governance

5.2.1 To evaluate the framework of internal control and corporate governance comprising the following components:

- Control environment; Risk management strategy, procedures and risk register;
- The effectiveness of the internal control and risk managements systems
- Decision-making processes;
- Receive and consider stewardships reports in key business areas.
- Information;
- Monitoring and corrective action

5.2.2 To review the system of internal financial control which includes:

The safeguarding of assets against unauthorised use and disposition;

- Maintenance of proper accounting records and

- The reliability of financial information used within the organisation or for publication.

5.2.3 To have a mechanism to keep it aware of topical legal and regulatory issues and ensure the Board's activities are within the law and regulations governing the NHS.

5.2.4 To monitor performance and best value by reviewing the economy, efficiency and effectiveness of operations.

5.2.5 To present an annual assurance statement on the above to the Board to support the Directors' Governance Statement on Internal Control.

5.2.6 To take account of the implications of publications detailing best audit practice.

5.2.7 To take account of recommendations contained in the relevant reports of the Auditor General and the Scottish Parliament.

5.2.8 To review audit reports and management action plans in relation to physical security of the Hospital.

5.2.9 To provide assurance to the Board that plans are in place to ensure service continuity and to provide contingencies for emergency situations.

5.2.10 To provide assurance to the Board that plans and mechanisms are in place to ensure that Fraud is properly monitored and reported.

5.3 Internal Audit

5.3.1 To review and approve the Internal Audit Annual Plan.

5.3.2 To review the adequacy of internal audit staffing and other resources.

5.3.3 To monitor audit progress and review audit reports.

5.3.4 To monitor the management action taken in response to the audit recommendations through an agreed follow-up mechanism.

5.3.5 To consider the Chief Internal Auditor's annual report and assurance statement.

5.3.6 To review the operational effectiveness of Internal Audit by considering the audit standards, resources, staffing, technical competency and performance measures.

5.3.7 To review the terms of reference and appointment of the Internal Auditors.

5.4 External Audit

5.4.1 To review the Audit Plan, including the Performance Audit Programme.

5.4.2 To consider all statutory audit material, in particular:
- Audit Reports (including Performance Audit Studies);
- Annual Reports;
- Management Letters.

5.4.3 To monitor management action taken in response to all External Audit recommendations including Performance Audit Studies (following consideration by the Staff Governance Committee or Clinical Governance Committee where appropriate).

5.4.4 To review the extent of co-operation between External and Internal Audit.

5.4.5 Annually appraise the performance of the External Auditors.

5.4.6 To note the appointment and remuneration of External Auditors and to examine any reason for the resignation or dismissal of the Auditors.

5.5 Standing Orders and Standing Financial Instructions

5.5.1 To review changes to the Standing Orders and Standing Financial Instructions.

5.5.2 To examine the circumstances associated with each occasion when Standing Orders are waived or suspended.

5.5.3 To review the Scheme of Delegation.

5.6 Annual Accounts

5.6.1 To review annually (and approve) the suitability of accounting policies and treatments.

5.6.2 To review schedule of losses and compensation payments.

5.6.3 Review the reasonableness of accounting estimates.

5.6.4 Review the external auditors management letter.

5.6.5 To review and recommend approval to the Board of the Annual Accounts.

5.6.6 To report in the Directors Report on the roles and responsibilities of the Audit Committee and actions taken to discharge those.

5.6.7 To review and recommend approval to the Board of the Patients Funds Annual Accounts.

6 AUTHORITY

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

7 PERFORMANCE OF THE COMMITTEE

The Committee shall review its own performance, effectiveness, including its running costs, and terms of reference on an annual basis.

The committee shall provide guidelines and/ or pro forma concerning the format and content of the papers to be presented.

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

Subject to annual review
This revision: approved April 2015, reviewed April 2019

THE STATE HOSPITAL BOARD FOR SCOTLAND

Date of Meeting:	20 June 2019
Agenda Reference:	Item: 18
Sponsoring Director:	Director of Finance and Performance Management
Author(s):	Head of Management Accounts
Title of Report:	Financial Position as at 31 May 2019
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 2019, which is also included in the Partnership Forum agenda, and sent monthly to Scottish Government with the financial template.

1.2 Scottish Government request a 1 Year Operational Plan (this was narrative only – with a financial template forecast submitted for a 3-year period). Draft went to last Board (25 April), meeting SG to discuss (5 June), and then final at the 20 June Board to confirm.

1.3 This Plan sets out a balanced budget for 2019/20 based on achieving £2.103m efficiency savings, as referred to in the tables in section 4.
There is a significant savings gap. This is depending on funding received for pay uplift, funding for sup'ers increase, whether we can capitalise the perimeter fence staff and if we only pay back the £0.220k towards the £15m territorial savings (and not the additional £0.127m intimated in the draft base allocation for 2019/2020).

2 BACKGROUND

2.1 Revenue Resource Limit Outturn

The annual budget of £37.095m is primarily the draft Scottish Government Revenue Resource Limit / allocation, and anticipated monies (still awaiting sup'ers increase RRL).

The Board is reporting an over spend position of £0.067m to 31 May 2019, the table below shows analysis by expenditure type.

Spend Type	Annual Budget £'k	Year to Date Budget £'k	Year to date Actuals £'k	YTD Variance (budget less actuals) for period 2	Budget WTE	Actual WTE (volume)
Other Operating Income	(582)	(97)	(91)	(6)	(2.00)	(2.00)
Pay	31,688	5,126	5,145	(18)	621.32	623.21
Savings	(1,992)	(90)	0	(90)	0.20	0.00
Purchase Of Healthcare	821	137	119	18	0.05	0.00
Non Pay	4,906	819	788	31	0.00	0.00
Hch Income	(603)	(135)	(129)	(6)	(9.07)	(9.22)
Capital Charges	2,857	476	472	4	0.00	0.00
	37,095	**6,236**	**6,304**	**(67)**	**610.50**	**611.99**

2.2 The table below highlights areas for the attention of the Board.

PRESSURES	Risk
National Pay Deal (only AFC funded)	Med
Holiday Pay (and possible retrospection) - Locke v British Gas	High
Rebandings (HR to advise)	High
Perimeter Fence - FBC - Additional Staff	Low
Contribution to £15m savings (Tranche 2)	High
BENEFITS	**Risk**
VAT element on Utilities in our favour (v HMRC)	Low

2.3 **Forecast Outturn**

The forecast outturn trajectory for the first month was an over spend of £0.087m, however the position is £0.067m overspent, therefore a favourable movement of £0.020m.

We have had late notification that HMRC has settled in our favour to reduce VAT on utilities to 5% from 20%, this windfall will benefit TSH in 2019/2020.

A year-end breakeven position was forecasted in the Operational Plan, but there are outcomes on a number of pressures still awaited.

3 ASSESSMENT

3.1 YEAR TO DATE POSITION – BOARD FUNCTIONS

Directorates	Annual Budget 19/20 £'k	YTD Budget May 19 £'k	YTD Actuals May 19 £'k	YTD Variance (budget - actual) (adverse) / favourable May 19 £'k	Budget wte	Actual WTE
Cap Charges	2,857	476	472	4	0.00	0.00
Central Reserves	18	30	0	30	0.20	0.00
Chief Exec	1,851	308	293	15	22.45	22.10
Finance	2,844	520	536	(16)	37.53	36.68
Human Resources Directorate	824	137	144	(7)	13.38	13.58
Medical	3,763	594	572	22	34.78	32.84
Misc Income	(294)	(49)	(2)	(47)	0.00	0.00
Nursing And Ahp's	19,390	3,232	3,297	(65)	378.53	389.28
Security And Facilities	5,841	989	991	(3)	123.63	117.51
Under / (over) spend	**37,095**	**6,236**	**6,304**	**(67)**	**610.50**	**611.99**

Key Highlights

Finance – legal fees pressure, invoice exceptionally high Apr and May 19.

HR – Occupational Health backdated invoice for 18/19.

Medical - Recharges to other Boards are higher than planned in base budgets, and **Psychology** – have continuing vacancies (due to continued closure of two wards).

Miscellaneous Income – targeted saving for VAT benefit on Utilities, not yet realised.

3.2 Further detail on Nursing & AHP's

Nursing & AHP's	Annual Budget £'k	Year to Date Budget £'k	Year to date Actuals £'k	YTD Variance (budget less actuals) for period 02	Budget WTE	Actual WTE
Advocacy	147	25	24	0	0.00	0.00
AHP's & Dietetics & SLA'S	645	108	105	3	12.83	12.70
Hub & Cluster Admin & Clinical Operations	809	135	133	1	23.17	21.62
PCI & Pastoral	219	37	28	8	3.40	2.40
NPD & Infection Control & Clin Gov	423	70	66	5	5.80	4.96
Skye Centre	1,720	287	246	41	38.33	32.27
Ward Nursing	15,427	2,571	2,694	(123)	295.00	315.33
Total Nursing and AHP's	**19,390**	**3,232**	**3,297**	**(65)**	**378.53**	**389.28**

Key Highlights

Skye Centre – has a considerable number of vacancies.
Ward Nursing - Some of the overtime is attributable to vacancies / under establishment, further analysis is required on explanation of the remaining balance.

Ward Nursing	2019/2020										
Ledger Nursing	Annual Budget £'k	Year to Date Budget £'k	Year to date Actuals £'k	YTD Variance (budget less actuals) £'k	Budget WTE	Actual WTE	Contracted/ conditioned wte's	Vacancies covered with o/t & excess wte's	Average monthly gross charge £'k	Overtime for Vacancies £'k	variance analysis required from Nursing Resource, mainly Pay & phased savings £'k
Total April 19		1,286	1,350	(65)	295.00	318.77	289.30	5.70	5	(26)	(39)
Total May 19		1,286	1,343	(58)	295.00	315.33	289.30	5.70	5	(26)	(32)
Cum May 19	15,427	2,571	2,694	(123)							

Further detail on Security and Facilities

3.3

Security & Facilities	Annual Budget £'k	Year to Date Budget £'k	Year to date Actuals £'k	YTD Variance (budget less actuals) for period 02	Budget WTE	Actual WTE
Facilities	4,206	701	689	12	83.86	75.12
Security	1,635	288	303	(15)	39.77	42.39
Total Security & Facilities	**5,841**	**989**	**991**	**(3)**	**123.63**	**117.51**

Key Highlights

Facilities – Repairs spend, held back March 19.

Security – Overtime, acting post.

Perimeter Fence staff have been 'funded' by increasing the savings gap, pending capital funding.

4 Savings

The target column of the table is an extract from the Operational Plan, further information shows savings achieved to date and remaining balance to be achieved by the year-end.

Savings Annual Target LDP	Savings Annual Target LDP 2019-20 Rec £'k	Non-Rec £'k	Total £'k	Savings (Achieved) YTD, as at May 19 2019-20 Rec £'k	Non-Rec £'k	Total £'k	Savings still to be achieved by year end 2019-20 Rec £'k	Non-Rec £'k	Total £'k
Efficiency & Productivity Workstreams:									
Service redesign (Clinical)	(22)	(95)	(116)	0	0	0	(22)	(95)	(116)
Drugs & Prescribing	0	(20)	(20)	0	3	3	0	(17)	(17)
Workforce	(57)	(481)	(538)	7	71	78	(50)	(410)	(460)
Procurement	0	0	0	0	0	0	0	0	0
Infrastructure *(e.g.facilities management, IT, other support services)*	(56)	(309)	(365)	0	5	5	(56)	(304)	(360)
Other	0	(100)	(100)	0	0	0	0	(100)	(100)
Financial Management / Corporate Initiatives	0	0	0	0	0	0	0	0	0
Unidentified Savings	0	(965)	(965)	0	25	25	0	(940)	(940)
Total In-Year Efficiency Savings	**(134)**	**(1,969)**	**(2,103)**	**7**	**104**	**111**	**(127)**	**(1,865)**	**(1,992)**
Trajectory (1/12ths of LDP)				22	328	351			
(under) / over achieved				(15)	(224)	(239)			

The following table, by Directorate, provides further clarification on savings.

As at May 2019	Savings - Annual Target	Achieved to date	(Still to be achieved) / over achieved
Directorate	**£'k**	**£'k**	**£'k**
Chief Executive	(162)	0	(162)
Finance	(99)	12	(87)
Nursing & AHP's	(261)	36	(225)
Human Resources	(33)	0	(33)
Medical	(117)	18	(99)
Security & Facilities	(367)	20	(347)
Unidentified (but plan to use contingency reserve)	(100)	0	(100)
Unidentified	(965)	25	(940)
Total	**(2,103)**	**111**	**(1,992)**

Around 5% savings have been achieved for the first two months of the year.

5 CAPITAL RESOURCE LIMIT

Capital allocation from Scottish Government is £0.269m.

Plans need to be prioritised to bring projected expenditure in line with allocation.

	Annual Plan £'k	YTD Plan £'k	YTD Actual £'k	YTD Variance £'k
Estates	114	26	26	-
IM&T	105	44	44	-
Vehicles	50	-	-	-
Other equipment	-	-	-	-
Security Fence Dvpt	-	-	-	-
TOTAL	**269**	**70**	**70**	**-**

6 RECOMMENDATION

6.1 **Revenue: Over spend of £0.067m year to date. Year-end projection: Breakeven.**

Overtime in Nursing is still higher than budget.

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.

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

6.2 **Capital: Breakeven year to date. Year-end projection: Breakeven**

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

MONITORING FORM

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

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	20 June 2019
Agenda Reference:	Item: 19
Sponsoring Director:	Finance & Performance Management Director
Author(s):	Acting Head of Financial Accounts
Title of Report:	Annual Review of Standing Documentation
Purpose of Report:	For approval

1 SITUATION

This report provides an update on proposed changes to Standing Documentation.

2 BACKGROUND

The Board is required, on an annual basis, to review and adopt any changes to Standing Documentation i.e. Standing Financial Instructions, Scheme of Delegation and Standing Orders. The Audit Committee reviewed the documents at their meeting on 28 March 2019 and their recommendation was then noted for the Board's adoption. Subsequent to the Board meeting of 25 April 2019, a full detailed review of the documentation has been undertaken and any outdated references removed or updated accordingly.

A national review of Standing Documentation format and content is underway, which is expected to provide all Boards with either standardised wording or structural guidelines to be followed. The output and timing of this report is as yet undetermined, and the Board will be notified once this is known, at which point these documents will be reviewed and updated in line with any recommendations arising.

3 ASSESSMENT

Aside from some minor typographical amendments, the undernoted changes are now reflected in the documentation.

3.1 Standing Financial Instructions

i Updated references to Local Delivery Plan – amended to Annual Operational Plan
ii Section 5.3.2 – updated to reflect requirement of two directors' signed authorisation to open any bank account in the name of the Hospital
iii Section 17 – Funds held in Trust – removed as no longer applicable to the Hospital with no endowment funds in place

3.2 Scheme of Delegation

i Sections 3.1, 7.2 – changed title from Involvement and Equality Lead to Person Centred Improvement Lead
ii Section 8.1 – corrected delegated authority from Director of Nursing and AHPs to Medical Director

3.3 Standing Orders

i Section 8 b) – added detail to clarify arrangements for Board meeting chairing in absence of Chairperson
ii Section 18 – specific reference included to Chairperson with regard to authority for dealing with the press
iii Section 21 – outdated wording removed from Annual Report reference (board remunerations, patient charter)
iv Section 25 a) – reference to Board minutes being signed at ensuing meeting removed due to being outdated
v Section 25 c) – reference to Board minutes being sent to SG replaced by reference to Board minutes being published on TSH website
vi Section 28 – reference to Common Seal removed

4 RECOMMENDATION

The Board is asked to approve the review of Standing Documentation.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives?	Ensures that the Board's standing documentation is up to date in respect of Scottish Government guidance and possible changes to Senior staff's portfolios.
Workforce Implications	None
Financial Implications	None
Route to the Board (Committee) Which groups were involved in contributing to the paper and recommendations?	Audit Committee
Risk Assessment (Outline any significant risks and associated mitigation)	No significant risks identified
Assessment of Impact on Stakeholder Experience	None identified
Equality Impact Assessment	No identified implications.
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	No identified implications.
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One √ There are no privacy implications. □ There are privacy implications, but full DPIA not needed □ There are privacy implications , full DPIA included.

Paper No. 19/46

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	20 June 2019
Agenda Reference:	Item: 20
Sponsoring Director:	Director of Security, Estates and Facilities
Author(s):	Head of Estates & Facilities
Title of Report:	Interim Property and Asset Management Strategy Update Report
Purpose of Report:	To approve the local Property and Asset Management Strategy Interim Report

1 SITUATION

The Scottish Government Health Finance, Corporate Governance and Value Directorate has written to Boards (Appendix 1) notifying them of the arrangements for the State of NHSScotland's Infrastructure (SAFR) programme and future submission requirements.

For this year's submission, a local Property and Asset Management Strategy (PAMS) interim update is required. This year's local PAMS interim update is required by Scottish Government Health Finance, Corporate Governance and Value Directorate in June.

The letter to Boards explains the content required in the update report.

2 BACKGROUND

The 2017 – 2022 PAMS was approved by the Board in June 2017 prior to submission to Scottish Government Health and Social Care Directorate.

3 ASSESSMENT

A report that meets the requirements of the letter from Scottish Government Health Finance, Corporate Governance and Value Directorate is attached at appendix 2.
It is proposed that, subject to Board approval, the finalised report is submitted to the Scottish Government Health Finance, Corporate Governance and Value Directorate.

4 RECOMMENDATION

That the Board **approves** the submission to the Scottish Government Health Finance, Corporate Governance and Value Directorate of the local PAMS interim update.

Paper No. 19/46

MONITORING FORM

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

Health Finance, Corporate Governance and Value Directorate
Christine McLaughlin, Director

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Scottish Government
Riaghaltas na h-Alba
gov.scot

James Crichton
Chief Executive
State Hospitals Board for Scotland

9 April 2019

Dear Colleague

State of NHSScotland's Infrastructure

Each year Health Facilities Scotland, on behalf of Scottish Government, notify you of the arrangements for the State of NHSScotland's Infrastructure (SAFR) programme and future submission requirements, which then forms the basis of the published information in this area. However, given the recent focus on estates and maintenance issues, it would be helpful if additional information could be provided in respect of high-risk backlog maintenance and the local governance arrangements in place for maintenance and estates.

High Risk Backlog Maintenance
Backlog maintenance is categorised into risk ratings which relate to clinical service and safety. High risk is where repairs or replacement must be addressed with urgent priority in order to prevent catastrophic failure, major disruption to clinical services or deficiencies in safety, which are liable to cause serious injury and/or prosecution.

Given the seriousness of high-risk backlog, I would expect that all high-risk backlog is reported on your corporate risk register and that there is a mitigation plan in place to address these high-risk areas; the attached pro-forma has been changed to capture this requested information.

Governance Arrangements
In addition to the specific issue on high-risk backlog, it would be helpful to understand what local governance arrangements are in place to provide you and your Board with the necessary assurance that maintenance and estates issues are being managed appropriately. Please provide a narrative that explains the controls that you have in place to provide that assurance.

Submission Requirements
I am also notifying you of changes to the State of NHSScotland's Infrastructure (SAFR) programme and future submission requirements. It should be disseminated to those responsible for the preparation and submission of your Property and Asset Management Strategy (PAMS) and associated pro-forma returns.

The programme is responding to the evolving planning arrangements taking place across NHSScotland, and the expectation for a more integrated approach to service and infrastructure change at local, regional and national levels.

The main proposed change is for Regional PAMS documents to be prepared and submitted on behalf of the territorial Boards, plus an Integrated PAMS document covering the National Boards. National Boards whose infrastructure is service specific (e.g. The State Hospital) may continue to submit an individual PAMS document if they so wish. It is anticipated that these new arrangements will take longer to implement and so new submission deadlines are proposed.

The new programme and submission requirements are as follows:

- Friday 7th June 2019 – submission of local pro-forma information by each NHS Board (continuing on an annual basis).
- Friday 7th June 2019 – submission of a local PAMS Update document by each NHS Board (similar to that submitted for this year's 2018 programme).
- Friday 20th December 2019 – submission of regional / integrated PAMS documents (draft versions will be accepted prior to formal governance approvals).

The pro-forma accompanying this letter are the same as in previous years, except there is no requirement for submitting an IM&T pro-forma this year and we have added a section to capture the above request relating to high risk backlog and proposed mitigation / resolution plans in place.

The PAMS Update report required by June 2019 is expected cover the following points:

- An update on progress towards developing a regional / integrated PAMS document by the end of the calendar year.
- Changes / improvements to your asset performance (including backlog maintenance) over the last 12 months. This should align with the performance data included within your asset pro-forma returns.
- Progress with any ongoing or new investment projects, particularly highlighting any specific achievements or anticipated benefits.
- As an annex to this report, Boards should also include Strategic Assessments for all investment projects identified within their 5-year investment programme.

The Regional / Integrated PAMS document will follow a similar format to a full local PAMS whilst also demonstrating an integrated, regional approach to health, care and infrastructure planning. It should also be aligned with any service change proposals described within the most current Regional Delivery Plan.

These proposals are not intended to restrict local reporting arrangements out with this programme. General queries on the above can be addressed to Paul Mortimer who leads this programme on behalf of Scottish Government and the National Infrastructure Board:
paulmortimer@nhs.net

Boards are thanked for their continued support with this programme.

Yours sincerely

Christine McLaughlin

Christine McLaughlin
Chief Finance Officer NHS Scotland, and Director of Health Finance, Corporate Governance and Value

State Hospital Interim Property and Asset Management Strategy (PAMS) Update Report to Scottish Government Health Finance, Corporate Governance and Value Directorate

This report addresses the issues identified in the letter of 9 April 2019 to The State Hospital's board Chief Executive regarding the requirement for a Local PAMS Interim Update Report.

- **Update on progress towards developing a regional / integrated PAMS document by the end of the calendar year**

  As a National Board, The State Hospital along with the other seven National Boards are tasked with producing a National PAMS by the end of the calendar year. There are regular Estates & Facilities meetings scheduled at a national level to develop a National Board PAMS.

- **Changes or improvements to asset performance including backlog maintenance over the last 12 months**

  Asset performance has not changed significantly over the last 12 months. As a result of the issues affecting Greater Glasgow & Clyde Health Board with regards ventilation and water, we have carried out audits to reassure ourselves that there are no similar issues that may affect The State Hospital. This has included assurance returns to Scottish Government.

  The backlog maintenance profile has not changed significantly over the year. The PAMS identified the backlog requirement as £5.05m, with £5m of this total attributed to the Perimeter Security Systems Refresh Project. In year funding has been available to address key issues within the remaining £50k.

- **Progress with ongoing or new investment projects**

  Over the coming year our most significant investment is the Perimeter Security Systems Refresh Project. This is estimated to be approximately £7m following a tender exercise and Full Business Case has been agreed by Scottish Government. The benefit of this investment is realised by the resilience maintained through replacement and improvement of detection, observation and prevention of systems around the perimeter.

- **Strategic Assessments for all identified projects within the 5 year investment programme**

  There are no identified projects within the 5 year investment programme that will require a Strategic Assessment.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	20 June 2019
Agenda Reference:	Item: 21
Sponsoring Director:	Finance and Performance Management Director
Author:	Clinical Effectiveness Team Leader
Title of Report:	LDP Performance Report 2018/2019 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 1st April 2018 until 31st March 2019 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 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 three 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).

Quarterly trend graphs have been included (Appendix 3) to show trends over time since 2017.

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 further in 2018/19 and the figure for March 2019 was 96.9% compared with 95.4% the previous year.

On 31 March 2019 there were 109 patients in the hospital. 8 of these patients were in the admission phase. 4 CPA documents had not been reviewed within the 6 month period. All 4 were out of date (one was completed shortly after the due date, the other 3 are outstanding).

Health Records staff continue to send reminder emails to RMOs and medical secretarial staff to advise that a patient's review or renewal of detention is due. The renewal of detention ties in with the annual CPA document being completed. These continue to be completed and uploaded to RiO by secretarial staff in shorter timescales than previously noted.

No 2 Patients will be engaged in psychological therapy.

Performance over the course of the year was consistently 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.

This indicator has seen an improvement from 78.7% in 2017/18 to 81.7% in 2018/19. There was slight fluctuation during the year that was mainly due to patient discharges and new admissions not being approved by the Clinical Team to attend activity at the Skye Centre.

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

The Health Centre consistently meets its targets. There was a slight dip in Q4 when invite letters were not sent for the month of March but this has been highlighted. 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.

This is the first full year that we have been able to report data for this indicator. The forms are being completed on RiO that now allows us to access physical activity data. The target of 60% was met in Q2 and Q3 but Q3 saw a reduction to 38.8%. Q4 saw an improvement to 59.3% just under the target. Overall for the year the 60% target was missed by 3.7%.

The reduction from 62.2% in Q2 to 38.8% in Q3 was, in part, due to the reduced number of hours patients can utilise ground access in the winter season. Other reasons included the 2 public holidays through the month of December whereby patients were unable to access facilities like the Sports and Fitness Centre, Gardens Department and walking groups either on a 1:1 or group basis.

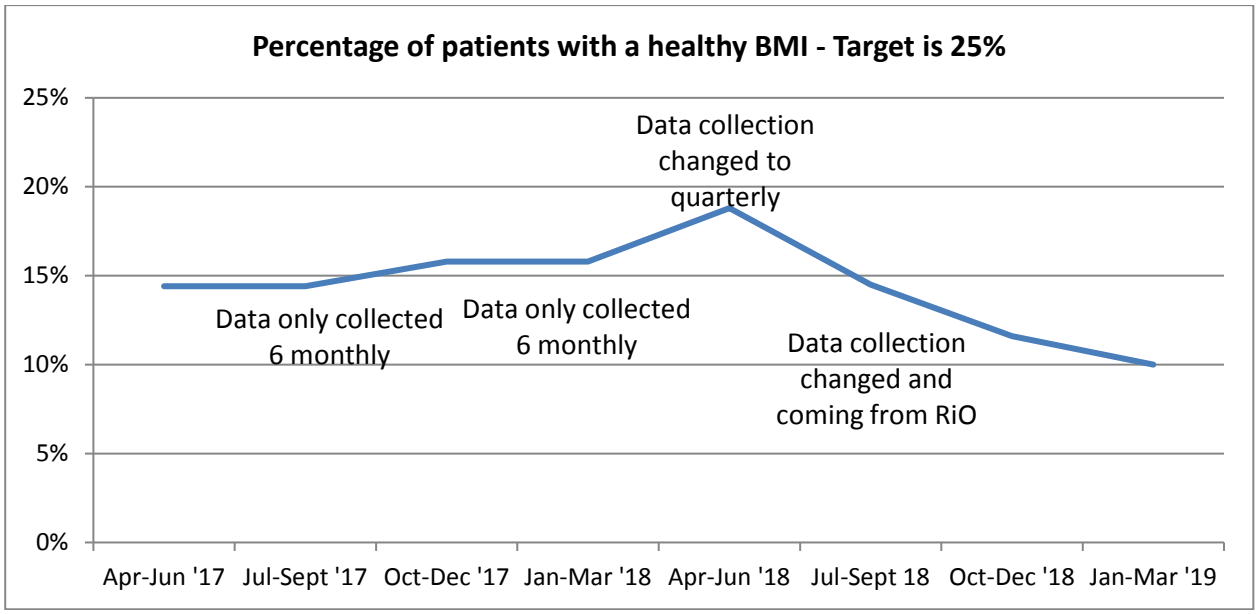
No 6 Healthier BMI.

The percentage of patients who have a healthier BMI decreased from 15.8% in the previous year to 13.7%. In Q3 it was shown to be down to patients with healthy BMIs being discharged and patients with unhealthy BMIs being admitted.

In 2018/19 the Supporting Healthy Choices Group action plan was delivered to improve BMIs. Some examples from the action plan were:

- 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 are being piloted.
- 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.

The data for BMI is now being input directly into RiO my nursing staff on the wards on a monthly basis rather than the dietetic assistant visiting wards on a 6 monthly basis to take these measurements. This allows for more frequent analysis on the BMI of our patients.



No 7 Sickness absence.

In the reporting period 1 April 2018 to 31 March 2019 the rate of absence was 8.26% compared to 8.52% in the previous year. This is against a 5% target.

The financial year 18/19 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.

The improvement plan includes 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 evidence of a reduction in absence from 2017 onward, the improvement work will continue until this is sustained.

No 8 Staff have an approved PDP.

The PDR compliance level at 31 March 2019 was 80.9%. Although this is a reduction from the 2018 figure of 84.7% it should be noted that a new system, called Turas Appraisal, officially went live in April 2018. This means that documentation for review is now completed electronically and recorded within Turas Appraisal.

Monthly monitoring is indicating a positive upwards trajectory and there is clear evidence of month-on-month improvements in organisational compliance throughout Quarter 4.

Staffing resource pressures and high levels of staff absence, which impact on reviewer and reviewee availability and capacity to undertake reviews, are a key contributory factors to lower levels of compliance in some wards and departments.

No 9 Patients are transferred using CPA.

97% of patients were discharged / transferred using the Care Programme Approach (CPA) against a target of 100%, which is a decline on last year's performance of 99%. The one patient who was not discharged using the Care Programme Approach was discharged to hospice care. This transfer was handled successfully with State Hospital staff supporting hospice staff for a number of days post transfer.

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. A Performance Management Task Force has been set up to review all the current KPIs and suggest more appropriate KPIs. Four logical models are being worked on at present as part of this piece of work.

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 2019 is 100%. 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 attendance target.

	Target	16/17	17/18	18/19	Increase/Decrease
RMO	90%	97.0%	94.8%	90.9%	-3.9%
KW/AW	80%	72.0%	75.2%	63.6%	-11.6%
OT	80%	48.0%	65.5%	64.2%	-1.3%
Skye Activity Centre	tbc	0.0%	1.0%	1.1%	0.1%
Pharmacy	60%	75.0%	57.2%	59.4%	2.2%
Psychology	80%	72.0%	69.6%	84.5%	14.9%
Security	60%	60.0%	59.8%	41.2%	-18.6%
Social Work	80%	76.0%	79.9%	80.8%	0.9%
Dietetics	tbc	12.0%	3.0%	23.6%	20.6%
Hospital Wide	**n/a**	**59.0%**	**57.9%**	**56.6%**	**-1.3%**

RMO – during 2018/19 there was a reduction in RMO attendance at case reviews. Whilst his reduced by 3.9% the 90% target was still reached.

Key Worker/Associate Worker – attendance by KW/AW has fallen by 11.6% to 63.6%. This is the lowest annual attendance figure since trend reporting commenced in 2012 and is 16.4% away from the 80% target.

Occupational Therapy – during 2018/19 there remained challenges with Occupational Therapy staff that resulted in some wards having no OT input. This was reflected within the attendance figures at annual and intermediate case reviews.

Psychology – there has been an increase of 14.9% attendance for 2018/19. This means that the target of 80% has now been met.

Security – Performance has reduced through the year with the target of 60% not being met. There has been an 18.6% reduction to 41.2% in their attendance at annual and intermediate case reviews during 2018/19. This is the lowest annual attendance figure since trend reporting commenced in 2012.

Dietetics – during 2018/19 attendance improved by 20.6% compared to the previous year. This is, in the main, due to the recruitment of a Dietitian post that had been vacant for some time.

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	
Workforce Implications	n/a
Financial Implications	n/a
Route To SMT Which groups were involved in contributing to the paper and recommendations.	Risk, Finance and Performance Management Group
Risk Assessment (Outline any significant risks and associated mitigation)	n/a
Assessment of Impact on Stakeholder Experience	n/a
Equality Impact Assessment	Not required
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	n/a
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One √ There are no privacy implications. □ There are privacy implications, but full DPIA not needed □ There are privacy implications , full DPIA included.

APPENDIX 1

Key Performance Indicators

2018/19: 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%	**100**	**94.9**	**96.9**	**96.1**	**LT**
	2	8	Patients will be engaged in psychological treatment	85%	**96.3**	**94**	**93**	**88**	**JM**
	3	8	Patients will be engaged in off-hub activity centres	90%	**81.7**	**79**	**84**	**82**	**MR**
	4	8	Patients will be offered an annual physical health review	90%	**100**	**100**	**100**	**71**	**LT**
	5	8	Patients will undertake 90 minutes of exercise each week	60%	**64.9**	**62.2**	**38.8**	**59.3**	**MR**
	6	8	Patients will have a healthier BMI (bi-annual audit)	25%	**18.8**	**14.5**	**11.6**	**10**	**LT**
	7	5	Sickness absence (National HEAT standard is 4%)	5%	**9.73**	**6.83**	**7.3**	**6.34**	**KS**
	8	5	Staff have an approved PDP	100%	**74.1**	**59.2**	**74.7**	**80.9**	**KS**
	9	1, 3	Patients transferred/discharged using CPA	100%	**100**	**87.5**	**100**	**100**	**LT**
	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**	**94**	**100**	**100**	**JM**
	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%	**100**	**98.1**	**98.1**	**99**	**LT**
	15		Refer to next table.						**All Clinical Leads**

Item	Code	Principles	Performance Indicator	Profession (Lead)	Target	RAG Q4	RAG Q3	Overall attendance Jan-Mar 2019 (n=42)	Overall attendance Oct-Dec 2018 (n=51)	Overall attendance July-Sept 2018 (n=44)	Overall attendance April – June 2018 (n=50)
15	T	2, 6, 7, 9	Attendance by all clinical staff at case reviews	RMO **(LT)**	90%	G	G	93%	90%	89%	92%
				Medical **(LT)**	100%	G	G	98%	96%	96%	98%
				Key Worker/Assoc Worker **(MR)**	80%	A	R	74%	49%	77%	58%
				Nursing **(MR)**	100%	G	G	98%	96%	96%	96%
				OT**(MR)**	80%	R	R	52%	61%	75%	68%
				Pharmacy **(LT)**	60%	G	R	71%	41%	59%	68%
				Clinical Psychologist **(JM)**	80%	G	G	79%	92%	80%	86%
				Psychology **(JM)**	100%	G	G	98%	98%	89%	96%
				Security**(DW)**	60%	R	R	41%	39%	34%	50%
				Social Work**(KB)**	80%	G	A	86%	71%	80%	88%
				Skye Activity Centre **(MR)** (only attend annual reviews)	tbc	-	-	0%	4%	0%	0%
				Dietetics **(MR)** (only attend annual reviews)	tbc	-	-	59%	30%	0%	0%

APPENDIX 2: KEY PERFORMANCE INDICATORS 2018-19 AND COMPARISION WITH 2017-18, 2016-17 AND 2015-16

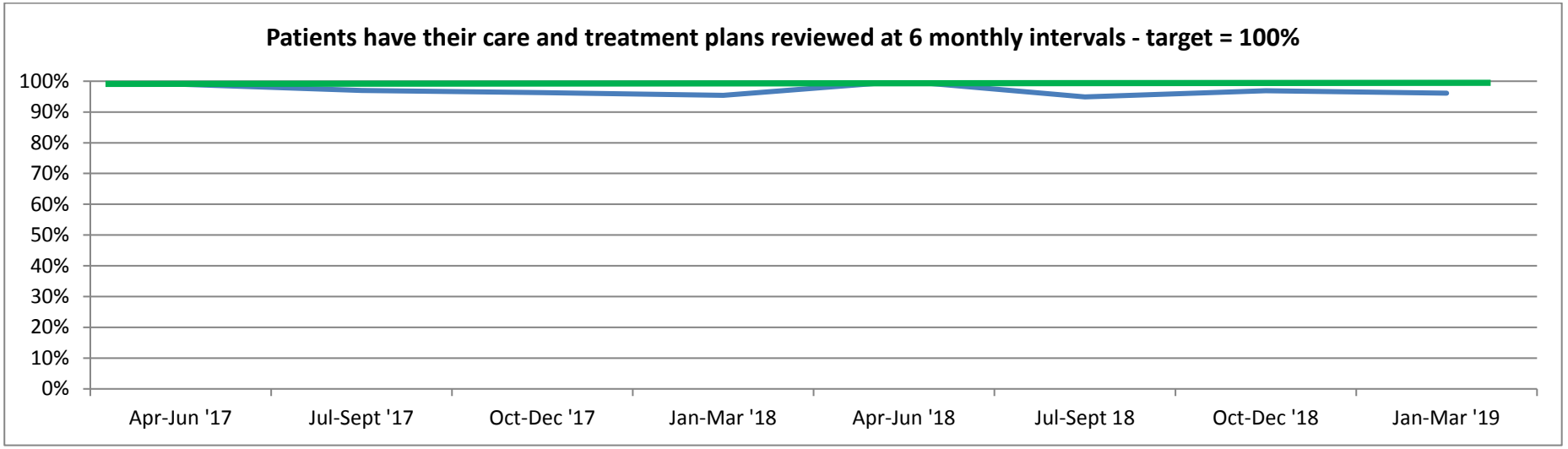
Item	Principles	Performance Indicator	Target	RAG	18/19	17/18	16/17	15/16		LEAD
1	8	Patients have their care and treatment plans reviewed at 6 monthly intervals	100%	G	96.9%	95.4%	91%	98%	*Figure to March each year.*	LT
2	8	Patients will be engaged in psychological treatment	85%	G	92.8%	94.4%	96.4%	90.6%	*Figure to March each year.*	MS/ GM
3	8	Patients will be engaged in off-hub activity centres	90%	A	81.7%	78.7%	79.3%	81%	*Attendance averaged for the year.*	MR
4	8	Patients will be offered an annual physical health review.	90%	G	93%	100%	100%	100%	*Figure for Apr 2018 - Mar 2019.*	LT
5	8	Patients will undertake 90 minutes of exercise each week (Annual Audit)	60%	A	56.3%	Q4 only 48.7%	-	-	*Average figure for April 2018 – March 2019*	MR
6	8	Patients will have a healthier BMI	25%	R	13.7%	15.8%	13.6%	15%	*Average figure from April 2018 – March 2019*	LT
7	5	Sickness absence (National HEAT standard is 4%)	** 5%	R	8.26	8.52%	8.35%	8.03%	*Figure for April 2017-March 2018.*	JW
8	5	Staff have an approved PDP	*100%	R	80.9%	84.7%	73%	82.7%	*Figure to March 2019.*	JW
9	1, 3	Patients transferred/discharged using CPA	100%	G	97%	99%	100%	100%	*Figures for April 2018 - March 2019. 1 patient in year.*	KB
10	1, 3	Patients requiring primary care services will have access within 48 hours	*100%	G	100%	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	98.5%	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%	99.1%	97%	97.3%	*Figure to March 2019.*	LT
15	2, 6, 7, 9	Attendance by all clinical staff at case reviews	See above	-	56.6% overall	57.9% overall	59% overall	59% overall	*Figures for April 2018- Mar 2019.*	All Leads

Definitions for red, amber and green zone

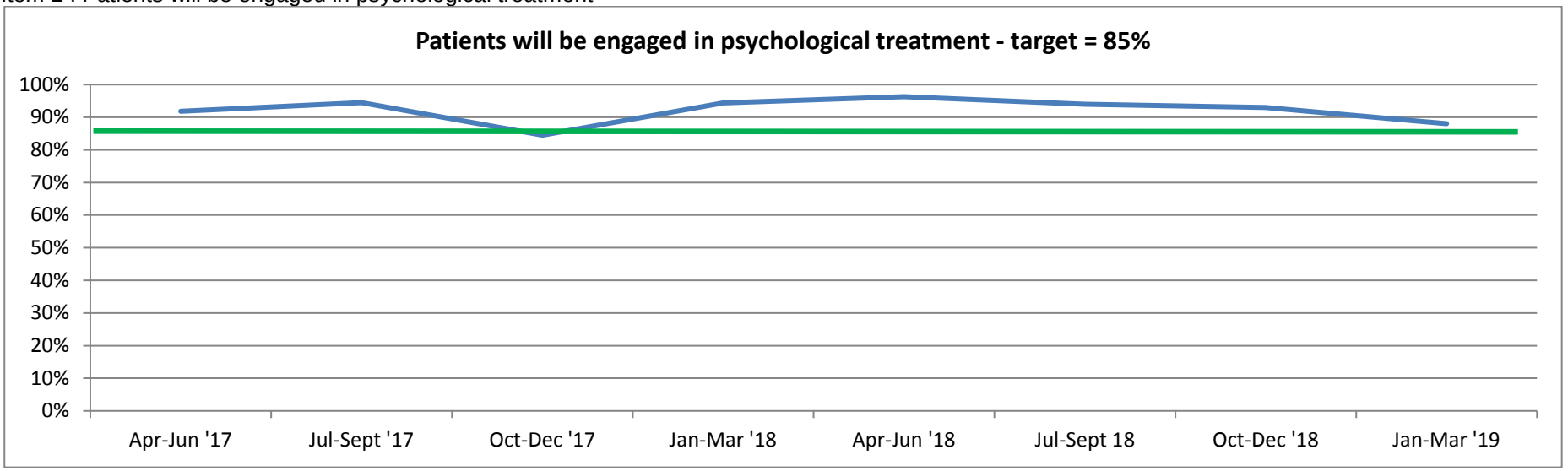
- For all but item 6 and 7 green is 5% or less away from target, amber is between 5.1% and 10% away from target and Red will mean we are over 10% away from target
- For item 6 'Patients have a healthier BMI' green will be 3% or less away from target, amber will be between 3.1% and 5% away from target and red will be over 5% away from target
- For 7 'Sickness absence' green is less than 0.5% from target, amber will be between 0.51% and 1% away from target and red will be over 1% and away from target

Appendix 3 : Trend Graphs for Performance Management Data

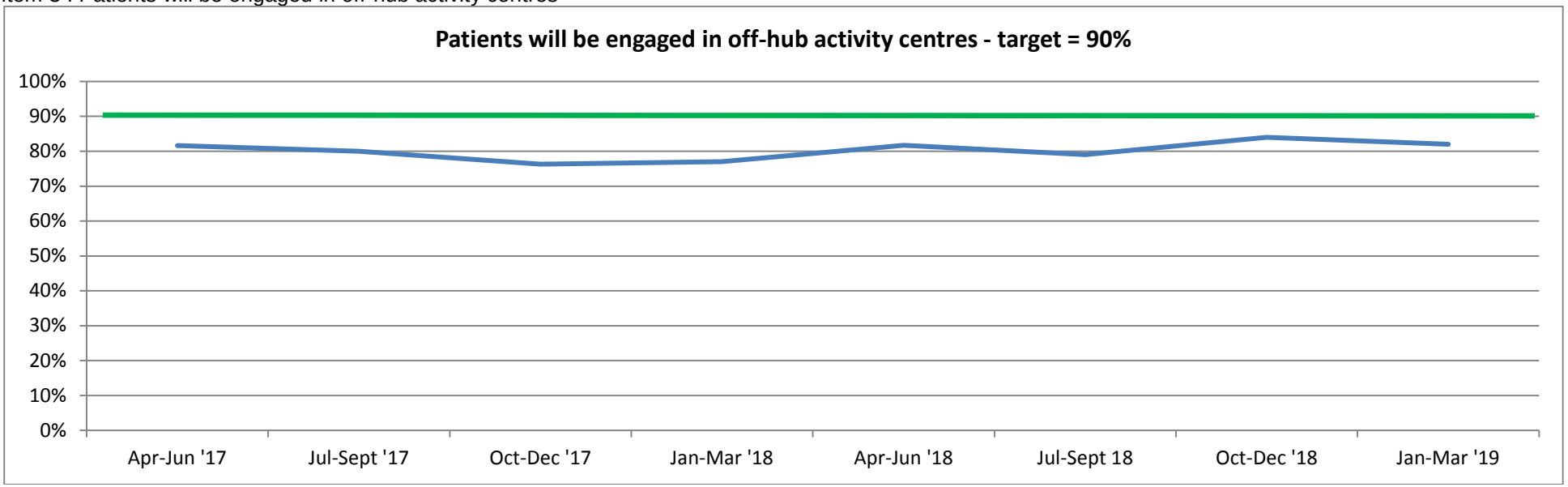
Item 1 : Patients have their care and treatment plans reviewed at 6 monthly intervals



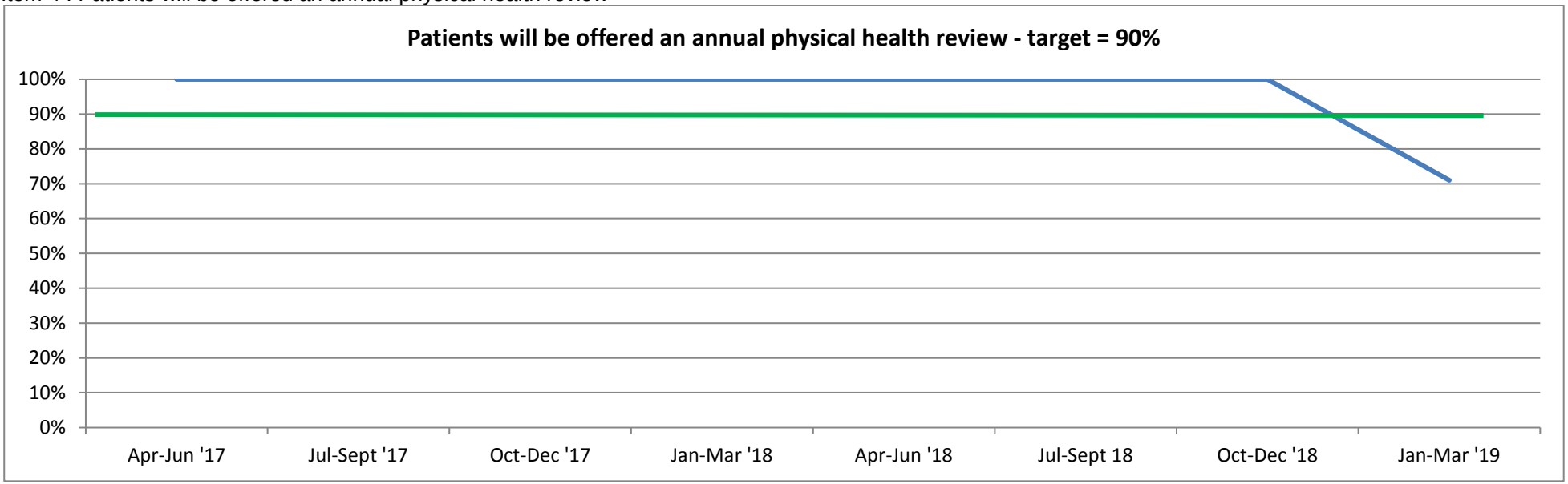
Item 2 : Patients will be engaged in psychological treatment



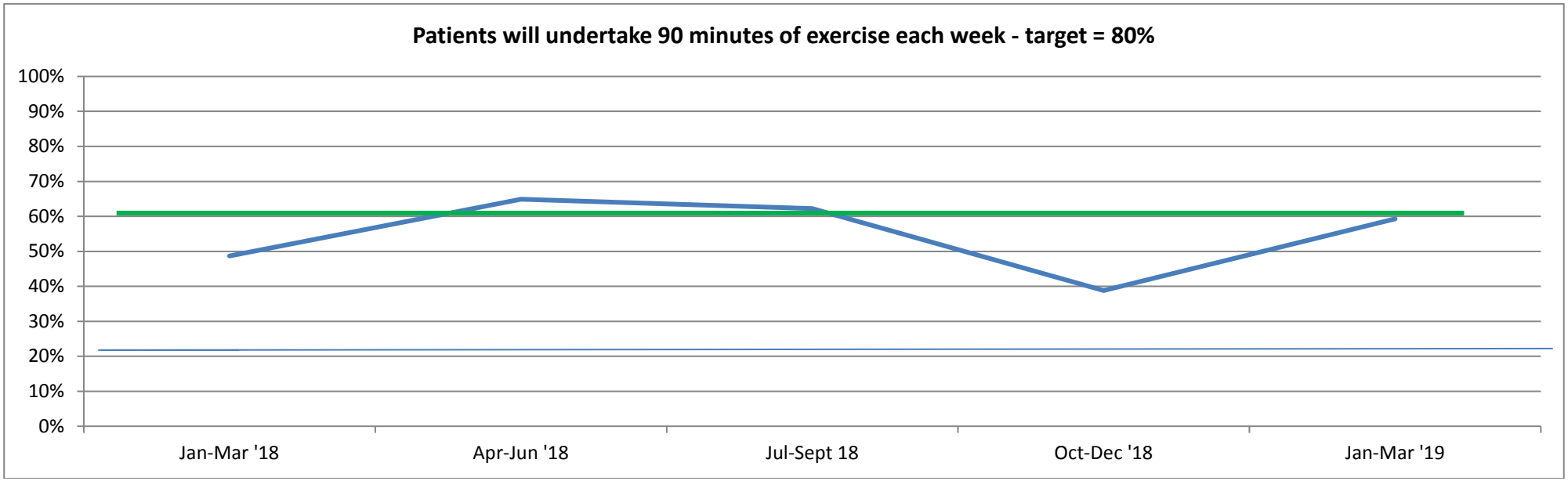
Item 3 : Patients will be engaged in off-hub activity centres



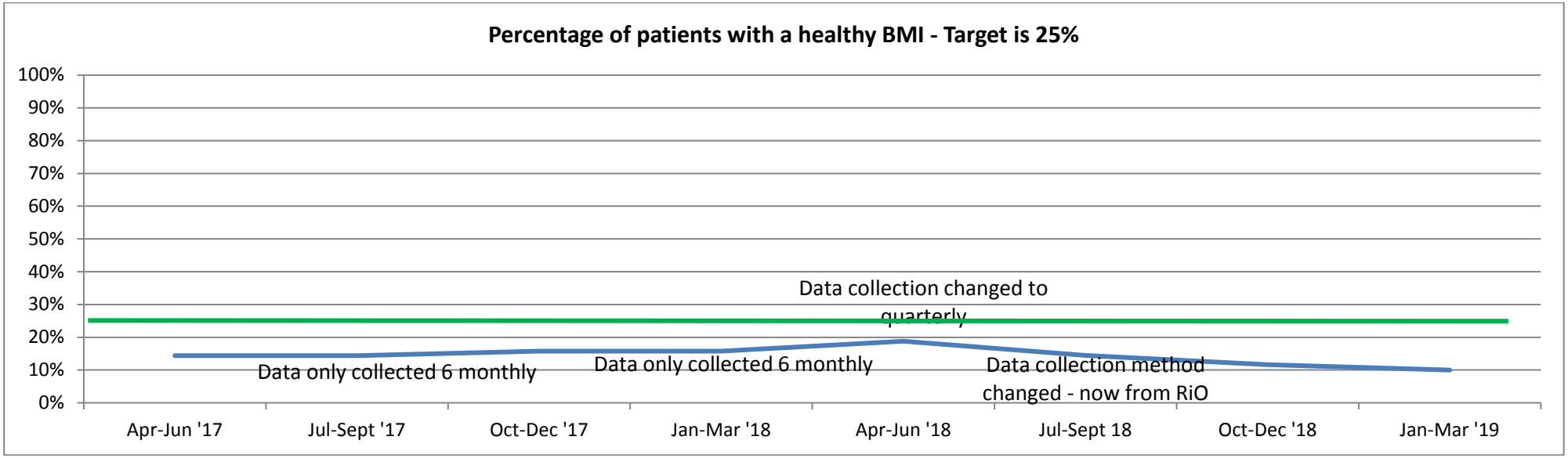
Item 4 : Patients will be offered an annual physical health review



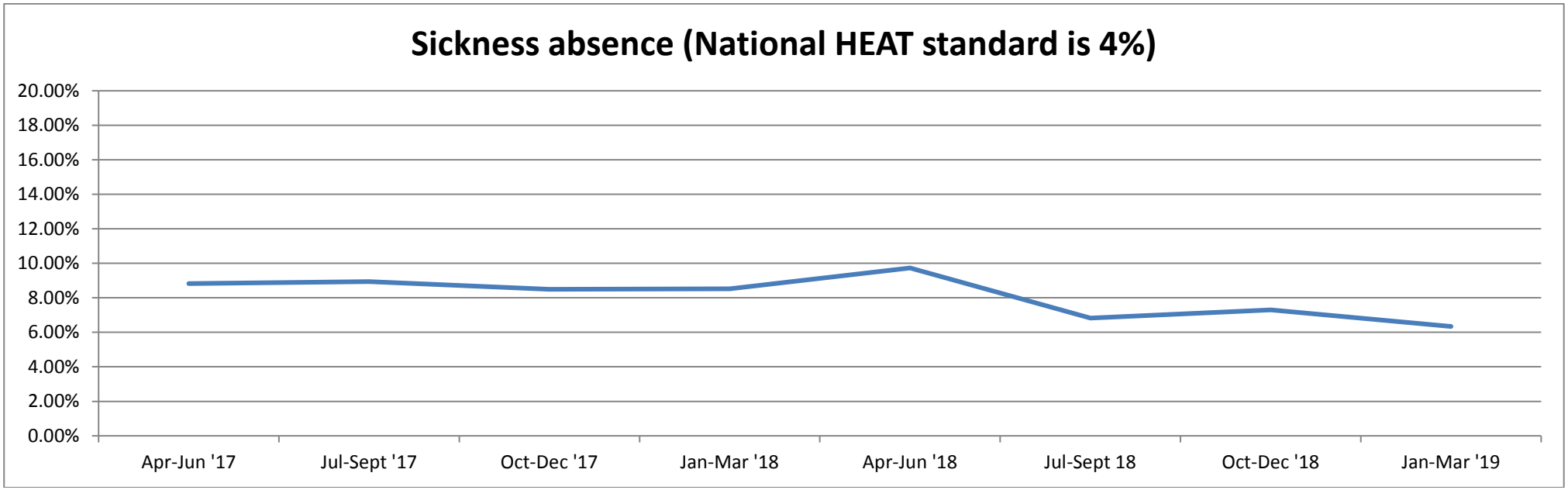
Item 5: Patients will undertake 90 minutes of exercise each week



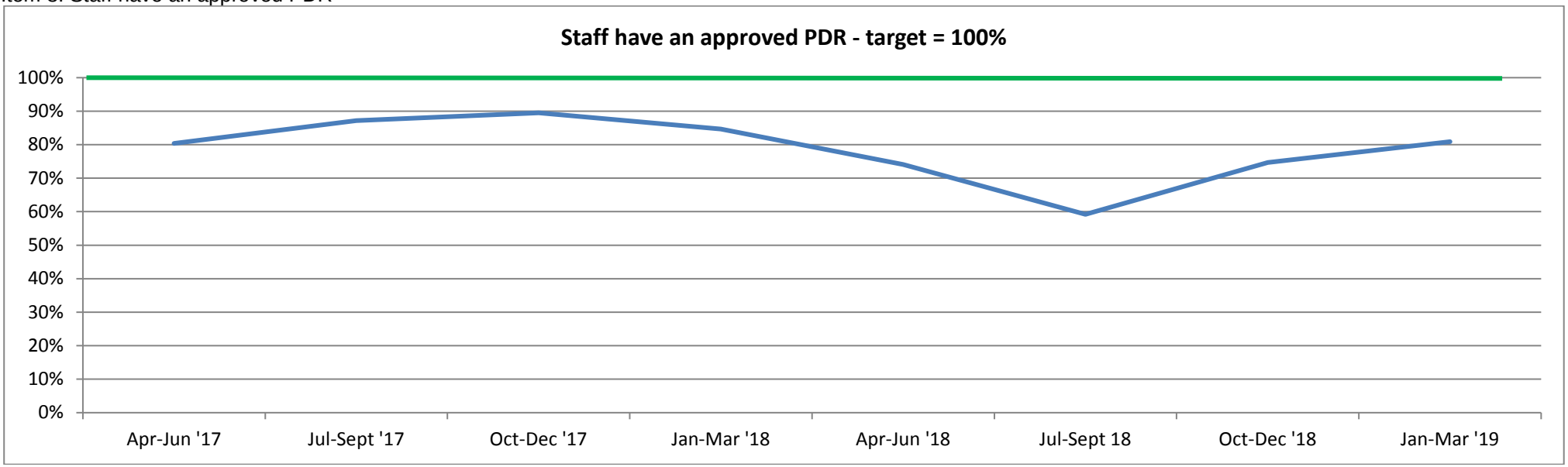
Item 6: Patients will have a healthier BMI



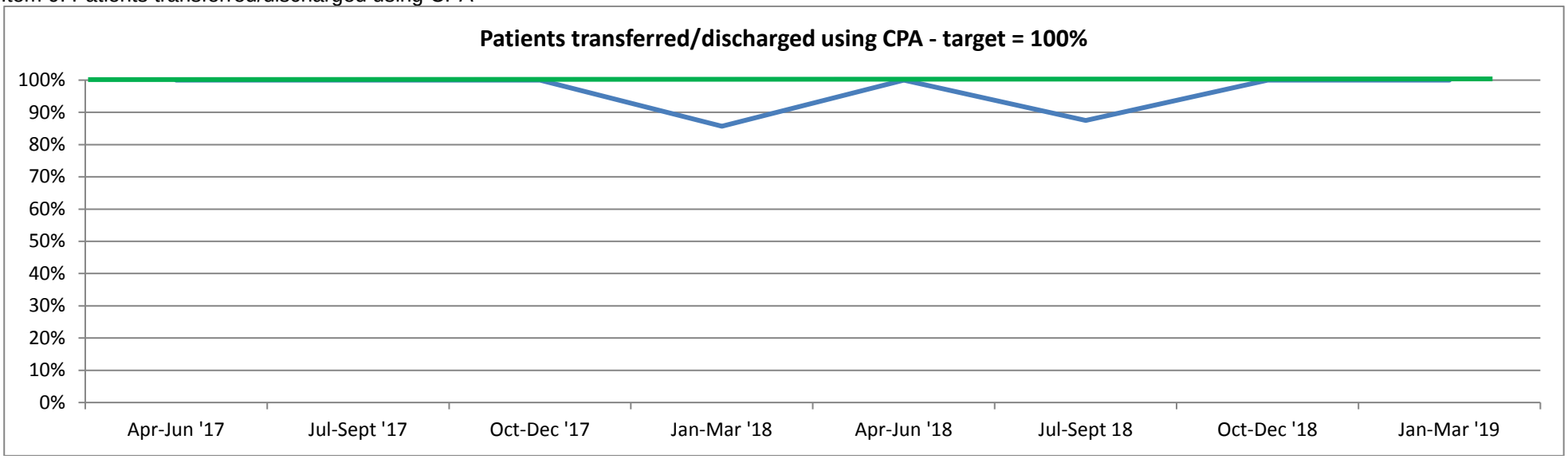
Item 7: Sickness Absence



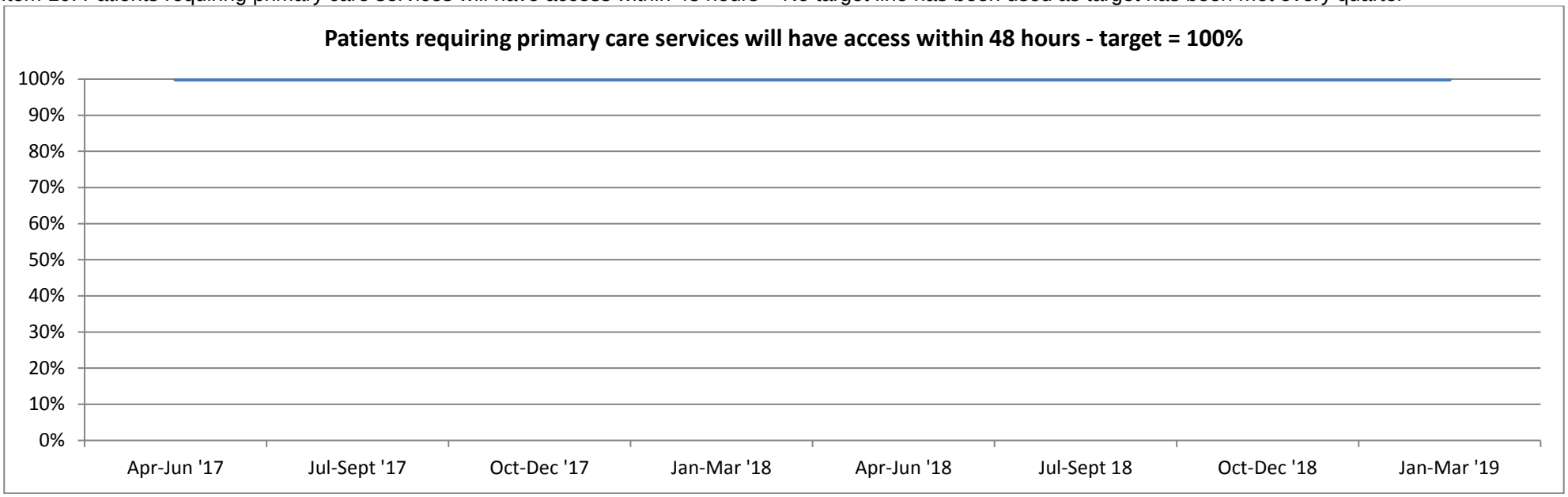
Item 8: Staff have an approved PDR



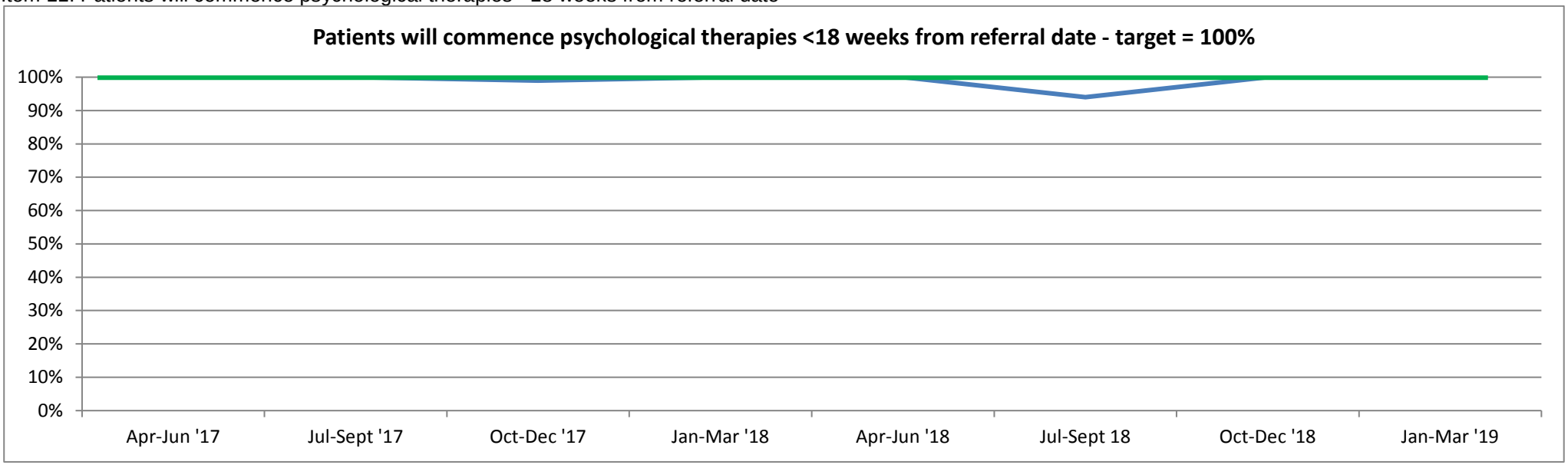
Item 9: Patients transferred/discharged using CPA



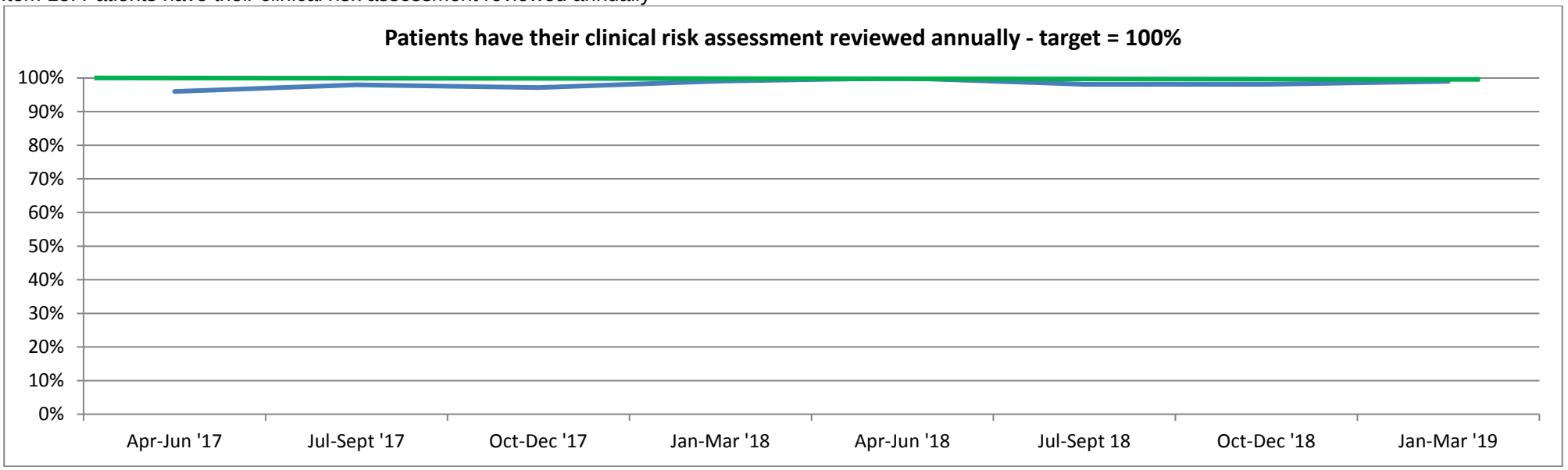
Item 10: Patients requiring primary care services will have access within 48 hours – No target line has been used as target has been met every quarter



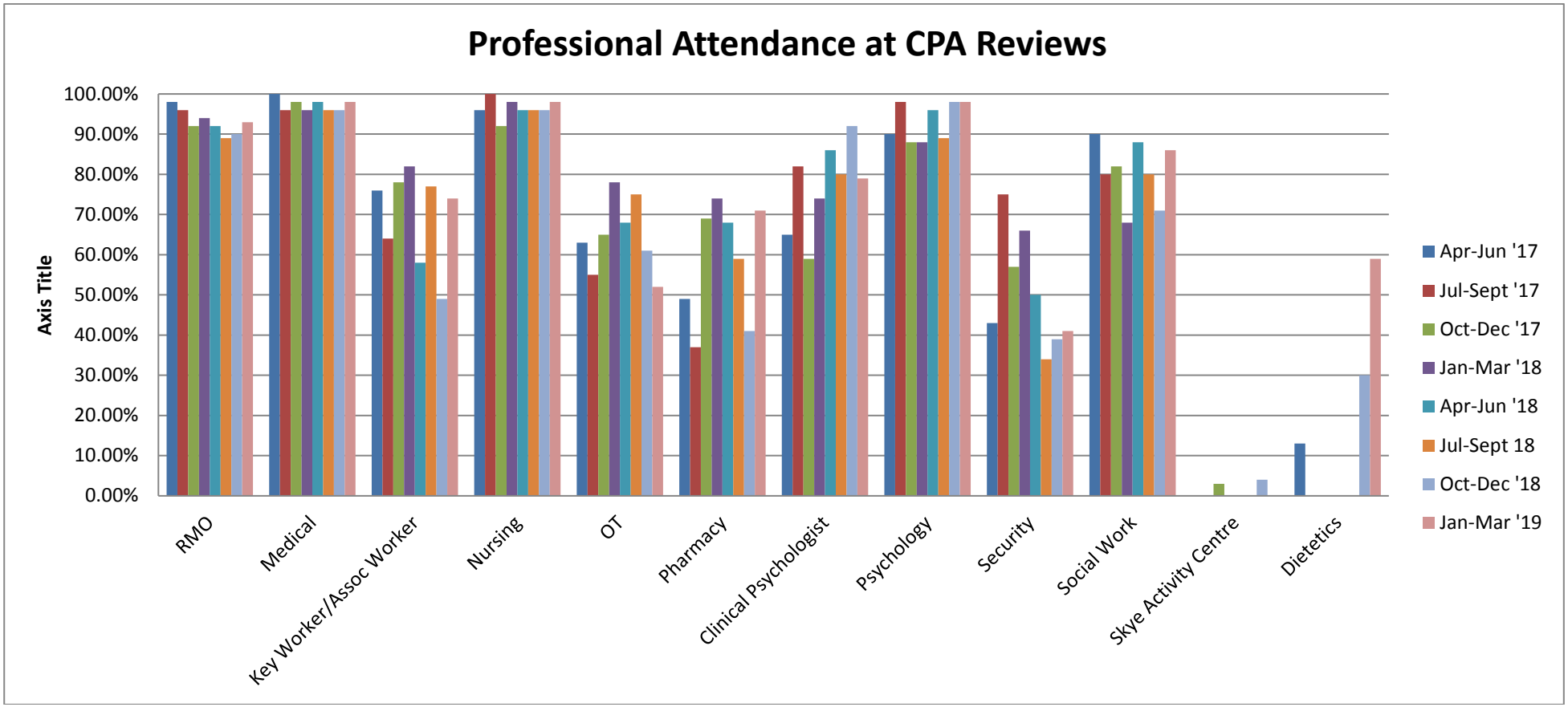
Item 11: Patients will commence psychological therapies <18 weeks from referral date



Item 13: Patients have their clinical risk assessment reviewed annually



Item 15: MDT Attendance at Case Review



Paper No: 19/48

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	20 June 2019
Agenda Reference:	Item No: 22
Sponsoring Director:	Chief Executive
Author(s):	Board Secretary
Title of Report:	Corporate Governance Improvement Action Plan
Purpose of Report:	For information

1 SITUATION

The Board took part in a self-assessment survey in February 2019 following development of the Corporate Governance Blueprint. This process has helped to clarify the key corporate governance priorities for the Board in the coming year. An improvement plan has been developed to support this work, and this was approved by the Board this at its meeting on 25 April 2019.

The Board submitted its report and improvement plan to Scottish Government by the required date of 30 April 2019.

2 BACKGROUND

This process has clarified the key corporate governance priorities for the Board in the coming year and the improvement plan supports this work in the five key areas outlined as follows:

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

The Board has requested that this item should be added to its workplan for 2019 and that an update on progress should be brought to each of its meetings.

3 ASSESSMENT

The improvement plan has been updated to indicate progress against each item (Appendix A) and the Board is asked to note the content of the updated plan, as well as the assurance mechanism through which progress will continue to be monitored.

In particular, the Board is asked to note the work progressed on the development of a strapline statement to be included on all corporate documentation. This should encapsulate The State

Hospital (TSH) mission for the provision of high quality, safe and secure forensic mental health treatment as well as the key TSH value of compassionate care.

This is being taken forward through engagement with the whole staff group. A competition has been launched in the hospital seeking ideas, and the closing date is 28 June. Entries will be collated and a winner picked by the Executive Lead team.

The Board is also asked to note the TSH Strategy Map for 2019/20 (Appendix B) which has been incorporated into the Annual Operational Plan for 2019/20. The Executive Lead team will review this in conjunction with the organisation's Corporate Objectives, as part of an Away Day for scheduled for July 2019.

4 RECOMMENDATION

The Board is asked to note progress in implementation of the improvement plan, and that a further update will be brought to the next meeting of the Board in August 2019.

Paper No: 19/48

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Corporate Governance Blueprint
Workforce Implications	None identified to date
Financial Implications	None identified to date
Route To Board Which groups were involved in contributing to the paper and recommendations.	Board Standing Committees/ SMT
Risk Assessment (Outline any significant risks and associated mitigation)	None identified to date
Assessment of Impact on Stakeholder Experience	Implementation will benefit stakeholder engagement through the workstreams indicated in the improvement plan
Equality Impact Assessment	Not formally assessed
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	No impact identified
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One √ There are no privacy implications. □ There are privacy implications, but full DPIA not needed □ There are privacy implications , full DPIA included.

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

BLUEPRINT FUNCTION		ACTION	LEAD	ASSURANCE SYSTEM	TIMESCALE	PROGRESS
SETTING THE DIRECTION	1	Reconfirm the Board's strategic direction, and communicate this through the Strategy Map and development of strapline statement for corporate documents.	CEO	CEBM	June 2019	Strapline competition underway and to close 28 June. Strategy Map reviewed and confirmed in Annual Operational Plan. Included in Executive Leads Away Day as part of review of Corporate Objectives.
	2	Review of effective rostering system within nursing as component of focus on effective workforce utilization and safe staffing legislation.	Director of Nursing and AHPs	SMT	March 2020	Review In progress.
	3	Development of more robust processes to compare planned and actual spend and to account for any variance.	Director of Finance	SMT /Board	September 2019	Update to October Board.
HOLDING TO ACCOUNT	4	Ensure compliance with new national guidelines in management of Executive pay and performance through remuneration Committee approval for annual ESM pay and performance cycle.	Chair /Interim HR Director	Remuneration Committee	Ongoing	On Track
	5	Ensure implementation of attendance management policy through support from HR to line managers help identify and act upon patterns of absence. Continued implementation of the action plan developed through the	Interim HR Director	AMITG/ SMT	October 2019	On Track. Training for Line Managers and HR Managers commenced. Update on attendance management to each Board Meeting

		Attendance Management Improvement Task Group (AMITG).				
	6	Implementation and compliance with Once for Scotland HR policies within TSH. Focus on policy awareness through completion of metacompliance / staff bulletins/ staff training in Single Investigatory process.	Interim HR Director	Partnership Forum/SMT	December 2019	On Track
	7	Review performance framework and assurance information systems to support review of performance.	CEO	CEBM	July 2019	Review in progress
	8	Blueprint Improvement Plan to be placed on Board Workplan for review at each Board Meeting.	Chair	Board	June 2019	**Completed**
ASSESSING RISK	9	Further development of risk management with focus on risk register to ensure this is clearly defined with set of mitigating measures against each risk which also have a focus on improvement actions.	Director of Finance	Audit Committee / Board	December 2019	Update to Audit Committee – September 2019
ENGAGING STAKEHOLDERS	10	Review and develop the Communications Strategy to include proactive engagement with aim of addressing dissonance between strategic aims of the hospital and public perception of these aims.	CEO	Board	March 2020	Review in progress with regular updates to the Board.

	11	Promotion of The State Hospital as an employer in the local area. Increase number of modern apprenticeships. Participate in local school careers events, local and university recruitment fairs	Interim HR Director	SMT	March 2020	Ongoing – engagement commenced in university recruitment fairs.
	12	Encourage carers / volunteers /staff / local population to attend public Board Meetings through additional promotion and links with local community.	Board Secretary	Board	September 2019	In progress – Update to October Board
	13	Hold two Board Meeting each year at external locations to promote role as national Board.	Board Secretary	Board	April 2020	Plan In progress – Update to August Board
	14	Annual Review - Public Meeting to be held outside of the hospital to help engage public engagement and attendance.	Board Secretary	Board	April 2020	Plan to be progressed as part of Annual Review 2018/19.
INFLUENCING CULTURE	15	Define culture in The State Hospital in terms of key strengths and weaknesses - take forward through development sessions	CEO	Board	December 2019	Review in progress – Update to December Board
	16	Implement a Staff Recognition Scheme for long service as well as individual contribution to the organisation.	Interim HR Director	SMT	September 2019	Nominations sought for each category with first ceremony scheduled for 25 September 2019.
	17	Embed a culture of quality across the organisation through initiatives such as TSH3030, Quality Forum and sharing our work more widely.	CEO	SMT	March 2020	QI Forum initiatives underway. TSH 3030 planning initiated for November 2019

	18	Senior Management visibility through regular front line staff engagement meetings with CEO / Directors' Group - plan a calendar of events to ensure regular engagement.	CEO	SMT	July 2019	On Track - CEBM weekly meetings scheduled across site. OD Lead supporting plan for engagement events – Update to August Board.
	19	Senior Team / RMO presence at key events in hospital calendar e.g. patient learning awards/ sportsman dinner. Promote this through management structures.	CEO / Medical Director	SMT	September 2019	Work progressed to coordinate central diary of events to help facilitate attendance
	20	Link in with Scottish Government once appointment of the Independent National Whistleblowing Champion has been appointed.	CEO	Board	April 2020	Under review.
	21	Plan a schedule of Non-Executive Director informal visits across TSH to help promote the values and behaviours of the organisation.	Chair	Board	August 2019	Update to August Board

Appendix B

The State Hospital Strategy Map 2019 – 2020

NHS Scotland aims to:

Provide high quality health care | Have financial sustainability | Improve population health

The State Hospital mission:

To excel in the provision of high quality, safe and secure forensic mental health treatment and care and to strive to be an exemplar employer

The State Hospital values are at the heart of what we do:

Care and compassion | Dignity and respect | Openness, honesty and accountability | Quality and teamwork

The State Hospital Strategic objectives:

Safety | Security | Effective care and treatment | Quality Improvement | Person centred

Key outcomes, by 2020 The State Hospital will have:

- reduced staff absence levels to 5% and increased workforce resilience
- reduced the proportion of patients with a BMI in the overweight and obese category and increased access to physical activity
- embedded a culture of continuous quality improvement and assurance to deliver excellent care
- ensured that the right staff are in the right place at the right time

THE STATE HOSPITALS BOARD FOR SCOTLAND

Minutes of the meeting of the Audit Committee held on Thursday 28 March 2019 at 9.45am in the Boardroom, The State Hospital, Carstairs.

PRESENT:

Non Executive Director	David McConnell **[Chair]**
Non Executive Director	Maire Whitehead

IN ATTENDANCE:

Internal

Board Chair	Terry Currie
Finance and Performance Management Director	Robin McNaught
Director of Nursing and AHPs	Mark Richards
Interim Human Resources Director	Kay Sandilands [Items 5-6]
Board Secretary	Margaret Smith

External

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

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

Mr McConnell welcomed everyone to the meeting. Apologies for absence were noted from Mr Bill Brackenridge, Mrs Anne Gillan and Ms Monica Merson. Mr Mark Richards was in attendance in place of the Chief Executive, Mr James Crichton, who had also offered apologies to the meeting.

NOTED

2 CONFLICTS OF INTEREST

There were no conflicts of interest noted.

NOTED

3 MINUTES OF THE PREVIOUS MEETING

The Minutes of the previous meeting held on 24 January 2019 were approved as an accurate record.

APPROVED

4 MATTERS ARISING AND ACTION NOTES UPDATE

Mr Richards provided an update on Action point three - in respect of the wider workforce (including non -professionally registered staff) being reminded on their duties around breach of confidentiality. He confirmed that appropriate reminders had been issued to all staff and that it was a mandatory requirement for all staff to complete an online learning module on information governance.

Mr McNaught provided a further update on the review of patients' funds - particularly those patients who do not meet the requirements for access to benefits. He noted that there were four patients within the hospital in this position. The payments were discretionary with no legal requirement to pay monies to these patients, but no legal barrier to doing so. A review of the individual circumstances indicated that to withdraw these payments could cause disadvantage and hardship. Members noted that in these circumstances, the payments should continue and the situation be kept under review, and were content with the decision resting with the Chief Executive Officer. Mr McNaught would ensure that this was noted within the policy.

Action - Mr McNaught

NOTED

5 ATTENDANCE MANAGEMENT REPORT

A report was submitted by the Interim Director of Human Resources (HR) which provided Members with an update on attendance across the organisation based on the data available from January 2019. Although this figure was 9.25%, there were early indications of a significant improvement for the month of February 2019.

Members noted the reasons for absence, highlighting the figure for anxiety, stress and other psychiatric illness. Ms Sandilands advised that the figure of 34.47% did not vary significantly with other NHSScotland Boards. Work was in progress with the Head of Psychological Services which was focussed on providing appropriate support to staff, particularly on preventative measures.

Ms Sandilands also highlighted the Once for Scotland national policies, and that the attendance management policy would be effective from 1 April 2019.

NOTED

6 LONG TERM SICKNESS ABSENCE TREND REPORT

A report was submitted by the Interim Director of Human Resources (HR) which provided Members with an update on the long term sickness trend data within the hospital. Members were content to note this report, following the discussion in the previous item.

NOTED

7 FRAUD UPDATE

A report was submitted by the Director of Finance and Performance Management to provide an update on fraud allegations and any notification received from Counter Fraud Services.

The Committee were content to note the detail of the report.

NOTED

8 FRAUD ACTION PLAN

The Committee received and noted the paper which provided an update on Board engagement with Counter Fraud Services (CFS). Mr McNaught advised that the annual review with CFS would take place later on this same day. A minor amendment was noted for the paper - as the workplan for CFS was note not yet to be available.

Action - Mr McNaught

Members also discussed and agreed that a review of the actions on the plan would be helpful with those actions already noted as closed being removed and the plan re-freshed.

Action - Mr McNaught

NOTED

9 CORPORATE RISK REGISTER UPDATE

The Committee received a paper from the Director of Finance and Performance Management which provided an update on the current risk registers.

Mr McNaught highlighted the key points noting that all risks were reviewed at the Risk, Finance and Performance Group which met on a quarterly basis. Further discussion in respect of the Corporate Risk Register would be picked up under Item 17 - Risk Management Audit Report.

NOTED

10 POLICY UPDATE

A paper was received from the Director of Finance and Performance Management, to advise of progress on updating of policies throughout the organisation. This continued to be led through the Clinical Effectiveness team. The good progress made to date was noted with a process of policy review and update agreed through the Senior Management Team (SMT).

Members discussed the consultation process for new or amended [policies?] with staff which included a three week period communicated through staff bulletins. This involved the policy holder undertaking review of the policy with a team of stakeholders as appropriate to each policy. Further was arrangements are in place in particular areas for detailed policy review e.g. the Infection Control Committee took a leading role in respect to infection control policies. It was also noted that, following consultation, all policies were submitted to SMT for final approval.

The Committee underlined the importance of staff engagement especially around cornerstone polices and indicated that there should be testing of the consultation process for robustness. Mr McNaught will take this forward, e.g. with a policy currently out for consultation.

Action - Mr McNaught

NOTED

11 CATEGORY 1 AND 2 ADVERSE EVENT REVIEWS

The Committee received an annual update report on all outstanding actions arising from Category 1 and Category 2 adverse event reviews, and noted that the Chief Executive took the lead in reviewing progress with the Director group.

In particular, it was noted that TSH was working with NHS Lothian in relation to Hospital Electronic Prescribing and Medicines Administration (HEPMA) in terms of the national programme.

Members expressed concern in respect of the timescales for completing adverse event reviews, and bringing these to SMT for approval. It was noted that a further report was being brought to the Clinical Governance Committee in this regard.

NOTED

12 RESILIENCE COMMITTEE - UPDATED TERMS OF REFERENCE

The Committee noted the minor changes made to the terms of reference for the Resilience Committee.

NOTED

13 AUDIT PROGRESS REPORT 2018/19

The Committee received a report from RSMUK which outlined the progress made against the internal audit plan for 2018/19. Mr Maccuzzio summarised the report noting that all 2018/19 assignments had been completed. He noted that two reports had been issued and finalised since the date of the last Audit Committee meeting, including a follow up review of previously issued partial assurance opinion reports and that reasonable progress had been made to address the weaknesses found.

The Committee noted this report.

NOTED

14 MANAGEMENT ACTION TRACKING REPORT

The Committee received and noted the tracking report from RSMUK in relation to management actions taken forward in response to internal audit recommendations, which outlined an improving position. It was noted that staffing capacity issues within eHealth had made progress more difficult in that area. RSMUK would also provide further support to the Board through an Internal Audit Action Tracker tool.

NOTED

15 DRAFT INTERNAL AUDIT PLAN 2019/20

RSMUK submitted the internal audit plan for 2019/20 for The State Hospital based on the organisation's corporate objectives, risk profile and Corporate Risk Register as well as other factors affecting the organisation in the year ahead, including any changes known to be planned by Scottish Government.

The plan submitted focussed on five key areas: implementation of the clinical model, rostering and scheduling of workforce, clinical observations, patient property and payroll.

The Committee reviewed the plan, and asked for some amendments. In particular the review of payroll transactions should be conducted in quarter 2 to allow sufficient breadth of oversight that this longer time period would provide. The Committee also asked for a review of how the organisation was identifying and tracking sickness absence patterns as well as the actions taken in response.

Action - Mr McNaught/RSM

On the basis of these amendments, the Committee approved the internal audit plan for 2019/20.

APPROVED

16 SICKNESS ABSENCE MANAGEMENT / POLICY AND PROCEDURE COMPLIANCE REPORT

The Committee was asked to note a report from RSMUK in respect of policy and procedure compliance - which provided a follow up opinion on progress made in implementing actions from the previous internal audit report. RSMUK reported that from their review and testing of the management actions, The State Hospital had made reasonable progress in implementing the actions outlined in the timeframe agreed upon.

The Committee noted the good progress made to date within Human Resources, as well as the need to sustain this progress.

NOTED

17 RISK MANAGEMENT AUDIT REPORT

RSMUK reported that an advisory review of risk management had been carried out as part of the approved Internal Audit Plan 2018/19. The report noted that whilst The State Hospital's risk management processes were still developing and being refined, the Corporate Risk Register was being actively monitored and reported upon to the Risk performance and Finance Group. The report identified further work required on risk management processes to ensure that risks and mitigating controls were properly defined and linked to strategic objectives. Further work was also identified in relation to local risk registers with clear escalation lines defined for transfer to the corporate risk register when appropriate.

The Committee noted the recommended actions within the report, and highlighted the importance of delivering on these.

NOTED

18 ANNUAL INTERNAL AUDIT REPORT 2018/19

A report was received from RSMUK providing their internal audit opinion on the overall adequacy and effectiveness of The State Hospital's risk management, control and governance processes. It was noted that of the seven reports issued in the year, three had provided a positive assurance opinion and four a negative (partial) assurance opinion. The areas in which partial assurance had been given were revisited by internal auditors either through bespoke follow up review or through routine management action tracking work. Given this follow up and the adequacy of controls at year end, RSMUK were able to provide an overall positive opinion that "The organisation has an adequate framework for risk management, governance and internal control".

The Committee noted and concurred with the advice given by RSMUK that The State Hospital should consider whether any of the control issues highlighted in the partial assurance reports should be included in its Annual Governance Statement together with the progress made to address the weaknesses identified. Mr McNaught noted that the draft governance statement would be shared with the Chair of this Committee as well as the Board Chair and Chief Executive.

Action - Mr McNaught

NOTED

19 INTERIM EXTERNAL AUDIT REPORT

Members received an update from Scott Moncrieff in their role as external auditor. Ms Karen Jones advised the Committee had been provided with a copy letter written to Mr Jim Crichton as Accountable Officer with a summary of findings following the 2018/19 interim audit visit to The

State Hospital in February 2019. The interim audit work had not identified any significant deficiencies in the adequacy or design of internal financial controls over the Board's financial systems. Ms Jones also asked the Committee to note that the final audit visit would take place in May 2019. The annual report on the 2018/19 audit would be presented to the June meeting of the Board.

The Committee were content to note this update.

NOTED

20 ANNUAL REVIEW OF STANDING DOCUMENTATION

The Committee received a report from the Director of Finance and Performance Management to advise that there were no proposed changes to the Standing Financial Instructions; Scheme of Delegation and the Standing Orders.

The Committee provided approval for this documentation to be submitted to the next meeting of the Board.

APPROVED

21 AUDIT COMMITTEE - TERMS OF REFERENCE

The Committee approved the terms of reference subject to one amendment - point 5.4.5 should be amended to note the additional role of the Auditor General in appraising the performance of the external auditors, further to any review by the Audit Committee.

Action - Mr McNaught

APPROVED

22 REVIEW OF ACCOUNTING POLICIES

A report was received from the Director of Finance and Performance Management to provide Committee with an update on the current position with regard to any changes to Accounting Policies based upon Financial Reporting Manual guidance.

It was noted that prior year adjustments are now replaced by retrospective restatements. IFRS16 on Leases is effective as of April 2019.

The Committee approved these changes.

APPROVED

23 ANY OTHER BUSINESS

The Board Chair, Mr Currie, advised colleagues that he had been invited by the Cabinet Secretary to remain in post until 31 March 2020 and that he had accepted this offer. The Committee offered its congratulations and support to Mr Currie.

NOTED

24 DATE AND TIME OF NEXT MEETING

The next meeting would take place on 20 June 2019 in the Boardroom, The State Hospital, Carstairs.

The meeting ended at 12 noon

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	20 June 2019
Agenda Reference:	Item: 24
Sponsoring Director:	Chief Executive Officer
Author(s):	Board Secretary
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.

3 PATIENT SAFETY UPDATE

New Patient Safety Principles were launched in March 2019. These are now: Communication; Leadership & Culture; Least Restrictive Practice and Physical Health. Work is ongoing to align current projects against the new drivers. Events are being held nationally at the end of June to educate those involved with SPSP MH to the new workstreams.

A brief summary of SPSP activity across the Hospital in the last two months includes:

Communication
Patient Support Plans continue to be implemented for those on increased observations and all new admissions and is an individually tailored guide that promotes person centred care. The key/associate worker is responsible for compiling the plan with patient input. This will be reviewed & updated with the patient during 1-1 for weekly review.

Leadership and Culture
Four walkrounds have taken place so far in 2019. Areas visited include Human Resources, Lewis 3, Mull 2 and Mull 1. Action are discussed monthly at the Chief Executive Business meeting and the Patient Safety group. The programme for 2019 has been agreed.

Least Restrictive Practice
The Clinical Pause has been rolled out to all Hubs. All Hubs have now had a formal intro session with Dr Skilling and the Clinical Pause process is now live on RiO. All hubs have now held Clinical Pauses. It is hoped and anticipated that the process will continue to iteratively change and improve with ongoing PDSAs/feedback.

Dr Skilling has also been approached by Rohallion and the Orchard Clinic to discuss how this could potentially be implemented in their environments.

- Improving Observation Practice (IOP)
  - Awareness raising is ongoing within MDT's
  - Collaboration with IOP Leads and HCIS re national policy template
  - GAP analysis completed for policy rewrite – Short life working group (SLWG) formed
  - SLWG invited to commence policy rewrite
  - Healthcare Improvement Scotland invited to SLWG
  - Collaboration with Occupational Therapy re hard to reach patients
  - Next stage of learning sessions organised for June x2
  - Roll out of Clinical Pause in Lewis
  - Specific Involvement in Lewis 1
  - Short Case study commenced – Lewis 1
  - Individual meetings with SCN's ongoing – receptive involvement
  - Successful Induction involvement ongoing

A qualitative Case Study regarding a patient within Arran Hub is now completed and has demonstrated the positive result of trauma informed practitioners, therapeutic engagement and core familiar staff. It has also identified the need for strong Leadership qualities among teams. The completed outcome of this case study will inform further learning sessions for staff and plans going forward to continue to improve observation practice. A quantitative research paper has now commenced and will highlight the specific improvements relating to Risk, Engagement and Staff Resource.

Physical Health
Gap analysis has been carried out in relation to new drivers. Work ongoing to align current hospital practice against these and identify/action any areas not being progressed. Link identified with PHPSG (K Burnett).

- Safer Medicines Management

The electronic PRN form has been implemented across all wards. This remains subject to weekly checks. Site wide improvements have been observed with the completion of the eform.

A presentation on tableau has been organised for the next Patient Safety Group to identify how this business management tool could be used to utilise the data collected at ward/hub level.

The Patient Safety group are keen to continue with Quality Improvement projects and maintain links with other groups in the hospital such as PMVA, TSH3030. TSH has been asked to present TSH3030 project at the national events in Glasgow and Edinburgh at the end of June.

4 HEALTHCARE ASSOCIATED INFECTION (HAI)

This is a summary of the Infection Control activity from 1st April – 31st May 2019 (unless otherwise stated).

Key Points:

- The submission and compliance of the hand hygiene audits continues to be a key priority which is monitored and reported both to this Board, Infection Control Committee and Senior Ward staff routinely. There has been a notable improvement in submissions since April.

- The compliance within the Skye Centre continues to be of concern and members of the Infection Control Committee are working alongside Security to see if there are physical improvements which can be made to aid compliance.

- DATIX incidents continue to be monitored by the Senior Nurse for Infection Control (SNIC) and Clinical Teams, with no trends or areas identified for concern.

- The antimicrobial prescribing is minimal in comparison to other NHS Boards; however the prescribing that occurs within The State Hospital is being monitored by the antimicrobial pharmacist for compliance with NHS Lanarkshire Antimicrobial Prescribing Formulary. The Infection Control Committee review antimicrobial prescribing quarterly with no trends or areas identified for concern. The SNIC is now a member of the Hospitals Medicines Committee.

Audit Activity:

Hand Hygiene

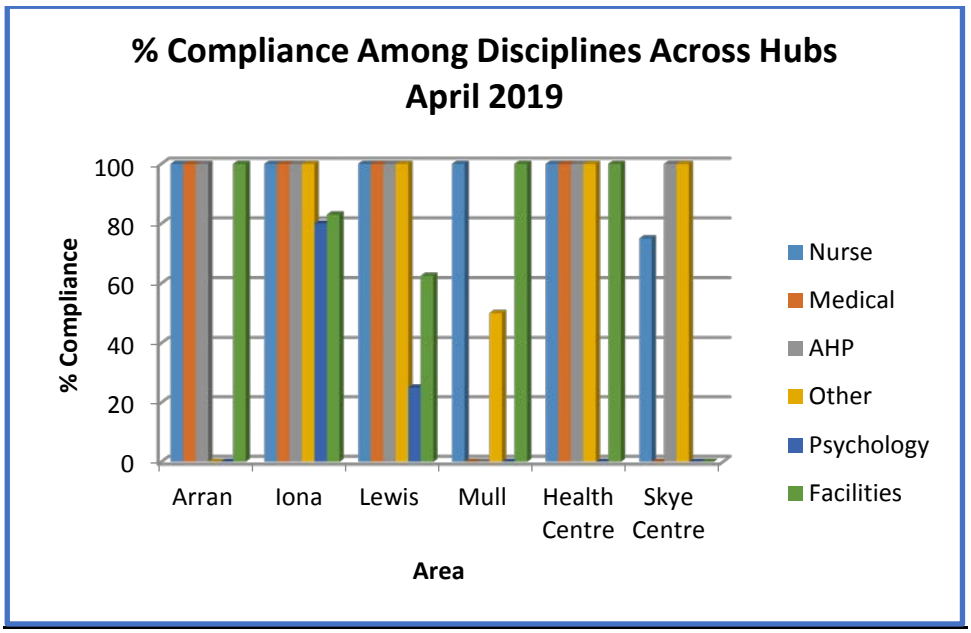
During this review period, there was a notable increase in the number of audits submitted.

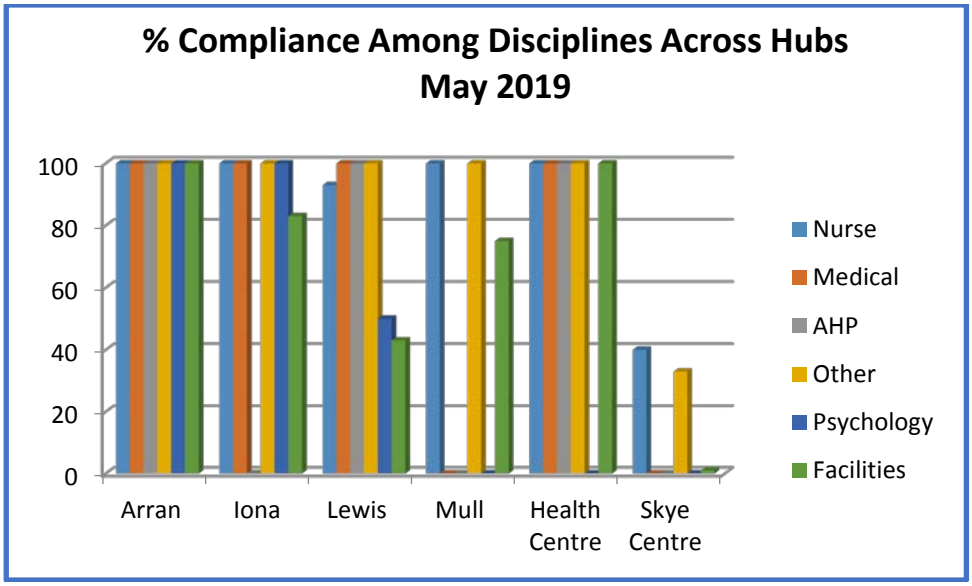
Reminders to submit and follow up of non compliance will continue to be carried out by the Senior Nurse for Infection Control.

April
12 out of a possible 12 were submitted.

May
12 out of a possible 12 were submitted.

The overall hand hygiene compliance within the hubs varies between 80-100%, with psychology continuing to be the discipline with the poorest compliance. The Skye Centre continues to remain low with significant variation 30-90% and the health centre consistently attaining 100%. The SNIC will undertake additional audits during the incoming months. The Charts below demonstrate the compliance among disciplines during the reporting period.





Following approval by the Senior Management Team both the product and the location of the hand gel within the Skye Centre was changed in September 2017. This was following feedback from those working in the Skye Centre. Unfortunately, these changes have not improved compliance within this area.

DATIX Incidents for Infection Control

There was a total of 12 incidents for the period under the Category of Infection Control, all of which relate to clinical waste (safe management of linen). This is being addressed by the SNIC, senior ward based nursing staff and Risk Management.

All Infection Control related DATIX incidents are investigated by the Senior Nursing Staff, clinical teams (as required) and reviewed by the SNIC to ascertain if there are learning outcomes identified. In addition, the Infection Control Committee is presented with this data quarterly.

Scotland's Infection Prevention and Control Education Pathway (SIPCEP) (previously Cleanliness Champions):

Following the launch of SIPCEP in September 2017 the ICC had advised that the four core modules should be completed within 6 months of implementation; however an extension was granted for three months but we have still not achieved the recommended target.

This will continue to be reviewed by the ICC quarterly.

Module	**Completions**		
	2017/18	**2018/19**	**Total (%)**
Why Infection Control Matters	301 (44.9% of target)	264 (39.3%)	**84.2**
Breaking the Chain of Infection	362 (54% of target)	233 (34.7%)	**88.7**
Hand hygiene	315 (new module) (47% of target)	266 (39.6%)	**86.6**
Respiratory and Cough hygiene	308 (45.9% of target)	263 (39.2%)	**85.1**

The remaining modules (allocated as per job requirement) are to be completed by 31st March 2020.

Module	**Completions**		
	2017/18	**2018/19**	**Total (%)**
Safe disposal of waste (inc Sharps)	*165 (35.9% of target)*	179 (37.4% of target)	**73.3**
PPE	*174 (38.9% of target)*	183 (38.2% of target)	**77.1**
Prevention and Management of Occupational Exposure (inc Sharps)	*166 (36.1% of target)*	182 (38% of target)	**74.1**
Blood and body fluid spillages	*201 (45.2% of target)*	176 (36.7% of target)	**81.9**
Safe Management of Care Environment	*120 (30.9% of target)*	155 (32.4% of target)	**63.3**
Safe Management of Care Equipment	*88 (26% of target)*	146 (30.5% of target)	**56.5**
Safe Management of Linen	*120 (30.9% of target)*	161 (33.6% of target)	**64.5**
Patient Placement/ Infection Risk	*92 (27.9% of target)*	140 (29.2% of target)	**57.1**

New staff will complete the priority modules within 6 months of employment with remainder of modules within 2 years of employment.

There is no data available for the reporting period as this is outwith the quarterly data reporting.

Hepatitis C Treatment

During this review period we have had 1 patient gain approval to commence a second attempt at treatment following his initial nil response. Funding is currently being sought from his home health board.

Queen Elizabeth University Hospital (QEUH)

Following a Healthcare Environment Inspectorate visit to the QEUH, all boards were asked to assess themselves against recommendations and requirements contained in report. The State Hospital completed this assessment and there are no areas of concern for the Infection Control Committee.

At a the Chief Nursing Officer's meeting with HCAI Executive Leads, it was suggested that Scottish Government host a workshop to reflect on lessons learned over the past year and to discuss the future landscape of HCAI. The SNIC will attend this workshop on 13th June and feedback to the Infection Control Committee.

Policies and Guidance

All infection control policies and procedures are being reviewed as per policy schedule and there are no outstanding policies.

5 PATIENT ADMISSION / DISCHARGES

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 1 April to 31 May 2019.

	MMI	LD	Total
Bed Complement (as at 31/05/19)	126	14	140
Staffed Beds i.e. those actually available (as at 31/05/19)	118	14	132
Admissions (from 01/04/19 – 31/05/19)	4	1	5
Discharges / Transfers (from 01/04/19 – 31/05/19)	7	0	7
Average Bed Occupancy (April – May 2019)	-	-	107 81% of available beds 76% of all beds

6 RECOMMENDATION

The Board is invited to note the content of the Chief Executive's report.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	To provide the Board with specific updates on patient safety, infection control and patient admission and discharges as well as any other areas specified to be of interest to the Board.
Workforce Implications	As detailed within sections 3 and 4 of report
Financial Implications	No financial implications identified
Route To Board Which groups were involved in contributing to the paper and recommendations.	Update from CEO to Board
Risk Assessment (Outline any significant risks and associated mitigation)	Not identified for this report
Assessment of Impact on Stakeholder Experience	Not identified
Equality Impact Assessment	Not formally assessed
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	Not identified as relevant
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One √ There are no privacy implications. □ There are privacy implications, but full DPIA not needed □ There are privacy implications , full DPIA included.