THE STATE HOSPITALS BOARD FOR SCOTLAND

BOARD MEETING

THURSDAY 22 AUGUST 2019
9.45am

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 20 June 2019	For Approval	TSH(M)19/06
4.	**Matters Arising:**		
	Actions List: Updates	For Noting	Paper No. 19/53
5.	**Chair's Report**	For Noting	Verbal
6.	**Chief Executive Officer's Report**	For Noting	Verbal
	CLINICAL GOVERNANCE		
7.	**Patient Story:** **Emotional Touchpoint Story on What Matters to You?** Presentation by the Director of Nursing and AHPs	For Noting	Presentation
8.	**Review of the Clinical Service Delivery Model – Update** Report by the Medical Director	For Noting	Paper No. 19/54
9.	**Medical Education – Annual Report** Report by the Medical Director	For Noting	Paper No. 19/55
10.	**Implementation of Specified Persons Regulations – Annual Report** Report by the Director of Security, Estates and Facilities	For Approval	Paper No. 19/56
11.	**Patient Safety, Infection Control and Patient Flow Report** Report by the Director of Nursing and AHPs	For Noting	Paper No. 19/57
12.	**Clinical Governance Committee** Chair's Report of meeting held 15 August 2019	For Noting	Verbal
	STAFF GOVERNANCE		
13.	**TSH Action Plan – in response to the Sturrock Report** Report by the Chief Executive	For Discussion	Presentation

14.	**Attendance Management – Board Update** Report by the Interim Director of HR	For Noting	Paper No. 19/58
15.	**Staff Governance Committee** Draft Minutes of meeting held 23 May 2019	For Noting	SG(M)19/02

CORPORATE GOVERNANCE

16.	**Finance Report to 31 July 2019** Report by the Director of Finance & Performance Management	For Noting	Paper No. 19/59
17.	**Performance:** **a) Strategic Review of Performance** Report by the Director of Finance & Performance Management **b) Performance Report – Quarter 1 2019/20** Report by the Director of Finance & Performance Management	For Noting	Paper No. 19/60 Paper No. 19/61
18.	**eHealth Annual Report 2018/19** Report by the Director of Finance & Performance Management	For Noting	Paper No. 19/62
19.	**Network Information Systems Regulation (NIS) and the Information Security Policy Framework (ISPF) 2018** Report by the Director of Finance & Performance Management	For Noting	Paper No. 19/63
20.	**Communications Annual Report 2018/19** Report by the Head of Communications	For Noting	Paper No. 19/64
21.	**Corporate Governance – Improvement Plan Update** Report by the Board Secretary	For Noting	Paper No. 19/65
22.	**Annual Review – Actions 2018/19** Report by the Chief Executive	For Noting	Paper No. 19/66
23.	**Audit Committee** Approved Minutes of meeting held 28 March 2019 Draft Minutes of meeting held 20 June 2019	For Noting	A(M)19/02 A(M)19/03
24.	**Board and Committee Meeting Schedule 2020** Report by the Board Secretary	For Approval	Paper No. 19/67
25.	**Any Other Business**		
26.	**Date and Time of next meeting** 24 October 2019, 9.45am in the Boardroom At The State Hospital, Carstairs, ML11 8RP		

27. EXCLUSION OF PUBLIC AND PRESS

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

THE STATE HOSPITALS BOARD FOR SCOTLAND ***TSH(M)19/06***

Minutes of the meeting of The State Hospitals Board for Scotland held on Thursday 20 June 2019 at 12.30pm in the Boardroom, The State Hospital, Carstairs.

Chair	Terry Currie
Present:	
Non-Executive Director	Bill Brackenridge
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:	
Head of Estates and Facilities	Kenny Andress [Item 20]
Skye Centre Manager	Jaqueline Garrity [Item 9]
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
Board Secretary	Margaret Smith
Director of Security, Estates and Facilities	David Walker

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

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

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 25 April 2019 were noted to be an accurate record of the meeting, subject to one minor amendment to the attendance.

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 Currie thanked Mrs Whitehead for her attendance at the NHS Board Chair's meeting that had taken place on 20 May 2019.

He advised that there were a number of actions arising from this meeting, and Mr Currie outlined these for the Board. The Chairs were asked to make themselves familiar with the 'Hospital at Home' programme and consider implementing such a programme in their Board Area. Chairs were asked to create an aligned process for identifying and implementing exiting good practice across all Boards. Further, Chairs were asked to ensure that they are aware of performance reporting processes in their Boards and raise issues with Scottish Government as early as possible.

Chairs were asked to provide feedback on the Annual Review process, particularly on how to better incorporate integration. Mr Currie advised that the follow up letter to the Annual Review, which took place at The State Hospital (TSH) on 14 January 2019, had been received from the Minister of Mental Health. This would be circulated to the Board, and brought to the next Board Meeting for review.

Action – Ms Smith

Mr Currie advised that Chairs had been asked to set out what they will do within their Boards to help meet the Citizens' Jury recommendations, which were grouped into the following themes:

- Inform and educate patients to ask questions
- Create a culture of shared decision making
- The organization of appointments
- Training for professionals
- Advocacy
- Patient information and records.

He confirmed that the Realistic Medicine lead for TSH, Dr Gordon Skilling was progressing this work and planned to hold a forensic network event to discuss the recommendations and to develop an action plan on implementation. Mr Currie had asked that Dr Skilling report to the Board to allow Members an opportunity to discuss and review.

The NHS Chairs had also discussed the Scottish Government response to Sturrock Review into NHS Highland. Mr Currie emphasised that whilst the Review only examined matters in NHS Highland, there was important learning and reflection for all NHS Boards and the Scottish Government. He noted that that Cabinet Secretary for Health and Sport had written to all Boards on 20 May 2019 asking that they consider the Review and look again at the effectiveness of their own internal systems, leadership and governance. This response should be submitted by 28 June 2019.

Mr Currie noted that one of the actions contained in the Scottish Government response was the introduction of an Independent National Whistleblowing Officer for NHS Scotland and that this would

be the Scottish Public Services Ombudsman. In addition, it was the intention to recruit new Non-Executive Whistleblowing Champions for each health board and have these in post by the end of 2019. These champions would scrutinise the health board's application of whistleblowing processes and would have the authority to raise concerns directly with the Scottish Ministers where they feel that issues have not been appropriately addressed.

Mr Currie also made the Board aware that Mr Malcolm Wright had been confirmed in the post of Chief Executive Officer and Director General for NHS Scotland.

NOTED

6 CLINICAL GOVERNANCE COMMITTEE – ANNUAL REPORT 2018/19

A report was received from the Medical Director, outlining the activity overseen by the Clinical Governance Committee throughout 2018/19, and the Committee Chair, Mr Johnston provided an overview of this. The Board approved the report, subject to very minor amendment, which would be highlighted to the Clinical Effectiveness Lead.

Action – Ms Smith

APPROVED

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 25 April 2019. She emphasised the breadth of work undertaken to engage with staff, patients and wider stakeholders.

Ms Merson then provided a summary of the progress made to date with a further feedback session held in May for Heads of Service and Senior Clinicians and on the emergent themes from staff engagement. Staff were eager to continue to engage in this way. She outlined the way forward through an options appraisal process, taken through development of a set of benefits criteria. Ms Merson outlined the involvement of the Clinical Forum with the establishment of a short life working group to give clarity on the meaning of each option. Ms Merson also underlined that financial analysis of each option was being progressed in tandem.

Professor Thomson emphasised the engagement through the Clinical Forum as a multi-disciplinary advisory committee, as well as operational nurse managers to ensure as wide engagement as possible through the options appraisal process. It was essential that all possible options were considered. As part of this engagement, the Clinical Forum were involved in nominating a wide cross-section of staff to participate in a visit to another high secure hospital in the U.K and provide feedback from this. The benefits criteria of each option would then be finalised in the next workshop, taking place in August 2019, with a formal options appraisal taking place in September 2019.

Board Members welcomed the progress made to date, particularly staff engagement, which had indicated a willingness to consider change carefully and in a pragmatic way. It was recognised that this was a huge project within TSH, and would require continued careful development. It would be important to continue to recognise the challenging financial backdrop, and to ensure that staff continued to feel invested in any structural organisational change.

It was noted that patient and staff safety were not specifically included in the benefits criteria, and Professor Thomson agreed that this should be the case; this had been recognised internally following submission of the paper to the Board and had been added.

It was agreed that a further update on progress should be brought to the Clinical Governance

Committee and to the Board in their meetings in August 2019, prior to submission of the finalised report on the result of the options appraisal to the Board at its meeting in October 2019.

Action – Professor Thomson/ Ms Merson

NOTED

8 HEALTH AND CARE STAFFING – UPDATE

A report was submitted by the Director of Nursing and AHPs, to update the Board on The Health and Care (Staffing) (Scotland) Bill which was passed by parliament on 2 May 2019 and was currently awaiting Royal Assent. Enactment of the legislation was expected in 2020.

In preparation for this, The State Hospital [TSH] was receiving funding until September 2020, to employ a part time workforce lead, working closely with Healthcare Improvement Scotland (HIS) to prepare to meet the requirements of the legislation, most particularly the Common Staffing Method.

Mr Jenkins added that this would be a significant change in focus for all NHS Boards, and it was essential to be able to describe what was needed within the organisation and plan accordingly. A further update would be brought to the Board at its October meeting.

Action – Mr Richards

9 SKYE CENTRE – 12 MONTHLY REPORT

A report was received from the Director of Nursing and AHPs, which provided an update to the Board on patient activity services within the Skye Centre for the period 1 June 2018 to 31 May 2019.

Ms Garrity was in attendance to lead Members through the detail of the report, emphasising the key pieces of work undertaken over the past 12 months, and the continued delivery of a quality service for patients. There was focus on the development of new activities for patients. She also asked the Board to consider the presentation of the information in the report, particularly tracking activity over time. Ms Garrity was pleased to advise the Board that the Skye Centre had recruited to the post of gardener, to ensure that this service could be provided to patients.

Mr Richards underlined the increase in the number of patients engaged in activity in the Skye Centre, and the positive direction of travel in this regard. Professor Thomson agreed that it was encouraging to see this improvement, and added that it was also essential to review the quality of the sessions undertaken. There was discussion around progress on the Patient Active Day, and Ms Garrity provided further background in terms of how this has been progressed including the work undertaken to consider patient feedback.

In response to a query on how to set a further target for improvement and monitor this, Ms Garrity confirmed that implementation of the electronic patient timetable will help to support this. The timetable would be used to capture both planned and ad hoc sessions. There was discussion around how patient attitudes to activities could impact on attendances as well as variance in clinical practice. Members were keen to support best clinical practice throughout the organisation, and Mr Jenkins confirmed that this would be taken forward to ensure equality of opportunity for all patients.

The Board welcomed this as a positive report, and thanked Ms Garrity and her team for the work undertaken throughout the year.

NOTED

10 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 9 May 2019. The Committee Chair, Mr Johnston, highlighted that the Research Committee had been noted as an area of good practice with reference to research study implementation as well as inclusion of patient feedback. An area of concern had been noted in relation to the Infection Control Committee in terms of hand hygiene practice in the Skye Centre and the downward trend in completion of infection control learning modules.

NOTED

11 STAFF GOVERNANCE COMMITTEE – ANNUAL REPORT 2018/19

The Board received a report from the Interim Director of Human Resources, outlining the key achievements and developments overseen by the Committee throughout 2018/19. The Committee Chair, Mr Brackenridge, provided an overview of the report, which was approved by the Board subject to one minor amendment. There had been five meetings throughout the year, but the meeting that took place on 5 April 2018 had been rescheduled from March 2018 due to very inclement weather.

APPROVED

12 REMUNERATION COMMITTEE – ANNUAL REPORT 2017/18

The Board received a report from the Interim Director of Human Resources, as a summary of the work undertaken by the Remuneration Committee throughout 2017/18. The Board approved this report subject to minor amendment on the date of the meetings, as well as noting that the Remuneration Committee will send reports to the Audit Committee, but does report directly to the Board.

APPROVED

13 RESPONSE TO THE CABINET SECRETARY FOR HEALTH AND SPORT – CULTURAL ISSUES RELATAED TO ALLEGATIONS OF BULLYING AND HARRASSMENT IN NHS HIGHLAND

Mr Jenkins introduced a discussion in relation to the Scottish Government Response to the Sturrock Review into Cultural Issues related to allegations of bullying and harassment in NHS Highland.

On 20 May 2019, the Cabinet Secretary for health and Sport had written to all NHS Board Chairs and Chief Executives requesting that they provide where appropriate:

- Details of immediate actions your Board have taken/ plan to take on the back of the recommendations made in the Sturrock report.
- What support your Board have put in place/ will put in place for any member of staff who has been affected by bullying and harassment.
- Details of your Board's plan for staff engagement to consider these recommendations and a timeline of when this will be carried out.

Mr Jenkins outlined the considerable progress made to date with discussions within the Partnership Forum the Senior Management Team, and the Staff Governance Committee. He had also engaged with a range of clinical groups within the hospital during this time and this had lent further opportunity to raise awareness of this engagement process.

At the Partnership Forum held in June, the Chief Executive and Interim HR Director had collated a list of themes and fed this back through the forum for discussion. Mr Jenkins went on to say that work was also being progressed to identify themes from previous iMatter reports, as well as from the engagement process underway on the review of the Clinical Model.

The emergent themes would be collated into a questionnaire for staff to complete during July 2019, weighting their views and priorities within the identified themes. In this way, the focus would be bottom up approach led by the whole staff group of the organisation. This would help inform the creation of an action plan for implementation thereafter.

Ms Sandilands added that the Executive Leadership would be participating in an Away Day session in July to lend additional focus to leadership within the Board.

It was noted that a response was due to the Cabinet Secretary for Health and Sport on the above points by 28 June 2018, and it was agreed that a copy of this would be circulated to Board Members thereafter.

The Board were content to note the progress made in, and the plan outlined, and that a further update would be brought back to the Board at its next meeting.

Actions - Ms Smith

AGREED

14 ATTENDANCE MANAGEMENT – BOARD UPDATE

A report was received from the Interim Director of Human Resources, to provide the Board with an update on attendance management within TSH, particularly sickness absence rates. It was noted from the report that sickness absence had reduced further to a rate of 6.34% in March 2019, and Ms Sandilands provided a further verbal update that this had been reduced further to 5.55% in April 2019. She highlighted that future focus should be particularly on longer term absences, in order to help support staff and bring further improvement.

The Board welcomed this report, and Ms Sandilands's further update, and noted the need to sustain focus in this area.

NOTED

15 STAFF GOVERNANCE COMMITTEE

The Committee Chair, Mr Brackenridge, provided a verbal report on the meeting that took place on 23 May 2019, which had focused on attendance management, compliance on personal development plans and statutory and mandatory training, as well as the Sturrock report. The minutes of this meeting would be presented to the Board at its August meeting.

NOTED

16 AUDIT COMMITTEE – ANNUAL REPORT 2018/19

A report was received from the Director of Finance and Performance Management, to summarise the work of the Committee as well as to support the Governance Statement to the Board as part of the Annual Accounts, in respect of internal controls.

The Committee Chair provided an overview of the report, and the Board were content to approve its

contents.

APPROVED

17 ANNUAL ACCOUNTS FOR YEAR ENDED 31 March 2019

A report was received from the Director of Finance and Performance Management, noting that the annual accounts had an unqualified audit opinion from the external auditors, Scott Moncrieff, and were approved by the Audit Committee at their meeting on the morning of 20 June to be adopted by the Board.

Mr McNaught asked Members to note that the paper referred to the Governance Statement and the Statement of Health Board Members' Responsibilities; as well as summarising the Audit Committee's responsibility in reporting to the Board that the accounts should be adopted. Further, that the authority to sign as required was given to the Chief Executive and the Finance and Performance Management Director.

The Board provided approval for the following:

- Chief Executive to sign the Performance report
- Chief Executive to sign the Accountability Report
- Chief Executive and Director of Finance and Performance Management to sign the Statement of Financial Position.

It was also noted (in relation to Patient Funds) that the full background report was presented to the Audit Committee which recommended approval by the Board. The Board provided approval on this basis.

The Board noted the positive feedback from the external auditors on the presentation of background papers to support their audit, from the Finance Department, and that this would be fed back to the team.

APPROVED

18 FINANCE REPORT AS AT 31 MAY 2019

A report was received from the Director of Finance and Performance Management, to present the financial results to 31 May 2019 [Month 2].

Mr McNaught advised that TSH was reporting an overspend at 31 May of £67k, compared to a £58k overspend at the same point last year, but that was much reduced at the time due to the actions taken just before the 2018 year end resulting in almost nil overtime in March 2018 impacting on the April 2018 payroll. He highlighted the need to continue to focus on the short-term nursing overtime position to ensure operational steps move forward towards lower long-term sustainable levels.

Mr McNaught highlighted a significant issue for TSH to address as the currently unidentified savings for the year, the next step being to engage with all budget holders in second-stage line-by-line budget reviews at the end of quarter 3. The unidentified balance was reduced so far by confirmation from Scottish Government that the 6% pensions uplift was being funded for 2019/20.

In addition, the capital project facilitation costs (such as escorting) would be included in the final project funding. With reference to the National Boards' collaborative discussions, TSH did not expect to be in a position to contribute anything over the currently recognised £220k consistent with 2018/19. Both of these factors would reduce unidentified savings, but there would still be a strong requirement for focus on all directorate savings opportunities. He noted that Finance were also evaluating the level of benefit to be received from the agreed application of 5% VAT on utilities in

place of 20%.The capital resource budget was anticipated to be fully utilised in 2018/19.

Members noted the report, and placed this within the context of the report to the Audit Committee by the external auditors in relation to the risk presented from attendance management as well as overspend on nurse overtime. Mr Jenkins advised that work was in progress through the Senior Management Team in relation to managing the nurse resource to deliver the service within core hours.

Mr McNaught confirmed that, as discussed at the last Board meeting, and with the year end accounts process now complete, there would be a review of the presentation of this finance paper to the Board.

NOTED

19 ANNUAL REVIEW OF STANDING DOCUMENTATION

The Board received a report from the Director of Finance and Performance Management to submit proposed changes to Standing Documentation. He also noted the work of the Corporate Governance Steering Group led by the NHS Chairs to provide national guidelines in relation to Standing Orders, and that an update on this was expected later in the year.

The Board approved the recommended changes as outlines within the report.

APPROVED

20 PROPERTY AND ASSET MANAGEMENT STRATEGY (PAMS)

A report was received from the Director of Security, Estates and Facilities to provide a local interim update for PAMS as required by Scottish Government.

Mr Andress was in attendance and provided Members with a high level summary of the paper, and noted that TSH along with other National Boards were tasked with producing a National PAMS by the end of 2019.

The Board approved the report to be submitted to the Scottish Government Health, Finance, Corporate Governance and Value Directorate.

APPROVED

21 PERFROMANCE REPORT 2018/19

A report was received from the Director of Finance and Performance Management, to provide a high level summary of organisational performance for the 2018/19. He advised that a review was underway led by the Head of Corporate Planning and Business Support to reframe and update the individual KPIs and the quality of the available information for each measure.This would tie in with the work being undertaken on Tableau data warehousing options and systems support that would improve the reporting and sharing of relevant information.

Members discussed the presentation of data to give more sophisticated data e.g. changes in patient BMI over time. Ms Merson advised that the Business Tableau project was aimed at providing these additional layers of data to help present the organisational performance report.

Board Members noted the content of the report.

NOTED

22 CORPORATE GOVERNANCE - IMPROVEMENT PLAN UPDATE

A report was received from the Chief Executive, and Ms Smith provided Members with an overview of the key details, noting that this improvement plan had been added to the Board Workplan and that an update would be brought to each meeting.

The improvement action plan had been updated to include a section to detail progress against each item. Work was progressing to develop a strapline for all corporate documents through engagement with the wide staff group who had been asked for their suggestions. This would be finalised and a strapline chosen at the end of the month. Ms Smith noted that a wide range of staff were actively participating in this project.

Ms Smith also advised that review of the Strategy Map would form part of the Executive Lead Away Day taking place in July in line with review of the Board's Corporate Objectives.

In response to a query on point 4 – compliance with national guidelines in management of Executive Pay, Ms Sandilands clarified that this was intended to note the new guidelines in place this year and a commitment to take this forward. The plan would be amended to indicate this.

Action – Ms Smith

In reference to the review of the nurse rostering system, Mr Richards clarified that this was being taken forward in conjunction with the national work on eRostering. However, it was acknowledged that TSH had internal work to progress internally in terms of any anomalies or hot spots in shift rostering.

The Board noted the report, as a helpful summary of the work being progressed across the organisation.

NOTED

23 AUDIT COMMITTEE

The Board noted that the minutes of the Audit Committee that took place on 28 March 2019 were approved at this morning's Audit Committee meeting and would be submitted to the next Board Meeting in August.

NOTED

24 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, including updates on Patient Safety, Infection Control and Patient Admissions and Discharge data.

Mr Jenkins provided an additional verbal update on his activities since the date of the last Board Meeting. He noted the work undertaken in response to the Sturrock Review as had been discussed during this meeting of the Board.

Mr Jenkins advised that he had a helpful and productive meeting with colleagues at the Mental Health Directorate within Scottish Government, with focus on the TSH Annual Operational Plan for 2019/20.

He also noted the two reviews currently underway, of the Mental Health Forensic Estate as well as

of the Mental Health Act, and noted that Mr Derek Barron would be visiting TSH in his role as Chair of the Review of the Mental Health Forensic Estate.

Mr Jenkins had also attended the Scottish Leadership Forum, on behalf of the Board and would continue to do so as the meeting would take place twice a year. He had also approached the Head of Integration at Scottish Government to schedule a meeting at TSH in the near future.

NOTED

25 ANY OTHER BUSINESS

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

NOTED

26 DATE AND TIME OF NEXT MEETING

The next meeting would take place on Thursday 22 August 2019 at 9.45am in the Boardroom, The State Hospital, Carstairs.

NOTED

27 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 20 June 2019

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

ACTION NO	AGENDA ITEM NO	ITEM	ACTION POINT	LEAD	TIMESCALE	STATUS
1	5	Chair's Report	Circulate Annual Review Letter and add to Board Agenda	M Smith	Immediate	**On Agenda**
2	6	Clinical Governance Annual Report	Amendment to report.	S Smith	Immediate	**Completed**
3	7	Review of Clinical Model	Update on progress	Prof. Thomson/ M Merson	August 2019	**On Agenda**
4	13	Sturrock Review	Update on TSH Response	K Sandilands	August 2019	**On Agenda**
5	22	Corporate Governance – Improvement Plan	Amendment to wording in place to clarify the action (point 4)	M Smith	Immediate	**On Agenda**

Board Paper 19/54

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 August 2019
Agenda Reference:	Item No: 8
Sponsoring Director:	Medical Director
Author(s):	Head of Corporate Planning and Business Support
Title of Report:	Review of Clinical Model
Purpose of Report:	Update the Board on progress

1 SITUATION

This report provides and update to The Board on a review and options appraisal process on The Clinical Model. The requirement to review 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 and engagement activity March – June.

3 ASSESSMENT

Options for change were identified through staff consultation and engagement. Following extensive engagement on these options there is now a need to move into a process of options appraisal to provide a robust approach to considering options and their potential impacts on the delivery of care.

The Clinical Forum have supported the options appraisal process in detailing each option for consideration to ensure that there is clarity on the meaning of each, consistency in the use of language and an exploration of what each option means for the delivery of care.

There are currently 6 options being considered including the status quo. 2 options are based on the 3 Hub 3 ward model, 3 options are based on Hubs operating with different functions and either 1 or 2 ID wards. These are detailed below:

Option 1: Status Quo

Option 2: 3 Hubs with 3 wards (Ward 1- Admission & Assessment, Ward 2- Treatment & Recovery, Ward 3- Transition) and 1 ID ward in separate hub

Option 3: 3 Hubs with 3 wards (Ward 1- Admission & Assessment, Ward 2- Treatment & Recovery, Ward 3- Transition) and 2 ID wards in separate hub

Option 4: 3 Hubs with different functions (Hub 1- 2 Admission & Assessment wards, Hub 2- 3 Treatment & Recovery wards, Hub 3- 2 Treatment & Recovery wards, Hub 4- 2 Transition wards and 1 ID ward

Option 5a: 3 Hubs with different functions (Hub 1- 2 Admission & Assessment wards, Hub 2- 3 Treatment & Recovery wards, Hub 3- 2 Treatment & Recovery wards and 1 ID ward, Hub 4- 2 Transition wards and 1 ID ward

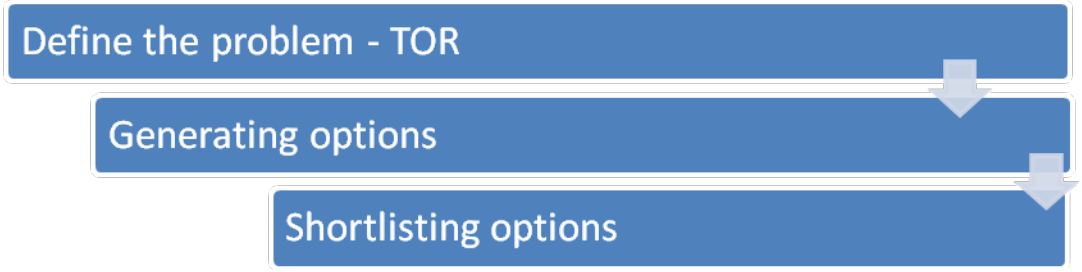
Option 5b: 3 Hubs with different functions (Hub 1- 2 Admission & Assessment wards and 1 Transition ward, Hub 2- 3 Treatment & Recovery wards, Hub 3- 2 Treatment & Recovery wards, Hub 4- 2 Transition wards and 1 ID ward

The Clinical Forum have identified the following terms to apply to all options

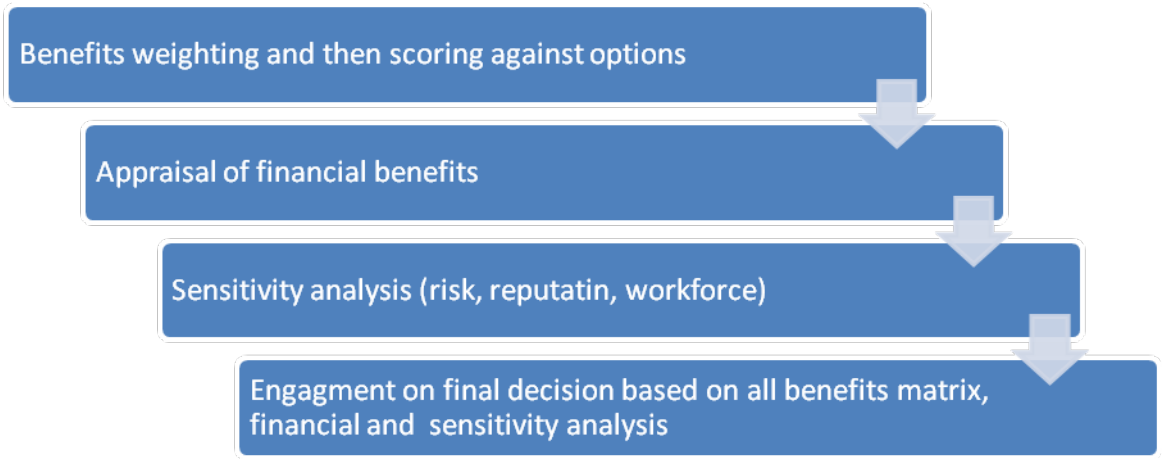
- Admission and Assessment wards: Agreed purpose of these should be about assessment. Restrictions should be standardised but based on the team's working understanding of the patient's risk..
- Treatment and Recovery wards: these wards need to be able to meet the needs of complex patients. Patients who are high risk, but where the risk is well understood and the management of their risk is clearly articulated with a defined care package, should be placed here.
- Transition wards: These wards are suited to patients whose risks and needs are well understood and articulated, and the level of care and management required is lower and less intense. They may have been identified as being ready to move onto less secure

Options appraisal Process

Steps in the Options Appraisal process



The above stages are complete. The next steps in Options Appraisal Process are:



Benefits Criteria
Draft benefits criteria have been developed and will be scored at workshop on 21st August
It is important that the benefits criteria are clearly defined to ensure that the scoring of each for the models is accurate and informed.

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.

Scoring of options
The proposed options will then be assessed against each benefits criteria, which will be weighted to provide an order of importance and priority. This will produce an overall position for the clinical assessment of what option best suits future needs of the hospital. This will be carried out at workshop on 16th September and any preferred options 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.

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 / Engagement
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.

Engagement
Staff, stakeholders, partnership and patient engagement will take place to share the outcome of the options appraisal process and gain feedback on this. The Board will be offered the preferred option to consider, alongside the process used to reach this. Following acceptance from the board an implementation plan will be developed which will take account of the magnitude of change and the processes required to implement this.

4 RECOMMENDATION

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

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.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 August 2019
Agenda Reference:	Item No: 9
Sponsoring Director:	Prof. Lindsay Thomson, Medical Director
Authors:	Dr Callum A MacCall, Dr Natasha Billcliff
Title of Report:	Annual Medical Education Report
Purpose of Report:	For Noting

1 SITUATION

The General Medical Council (GMC) Quality Improvement Framework for Undergraduate and Postgraduate Medical Education in the UK sets out expectations for the governance of medical education and training. GMC standards specifically refer to Board governance and it is within this context that this report is being presented to the Board. This report covers the period 1 August 2018 to 31 July 2019.

2 BACKGROUND

Dr Callum A MacCall is Educational Supervisor at The State Hospital. He is responsible for postgraduate medical training while Dr Natasha Billcliff leads on issues relating to medical undergraduates.

The medical staff group within The State Hospital hold a 3 monthly training committee meeting which is chaired by Dr Callum A MacCall. This committee reviews training issues of relevance to the Hospital. The Educational Supervisor reports within The State Hospital to Professor Lindsay Thomson, Medical Director. He reports externally to the Training Programme Director for Forensic Psychiatry Higher Training in Scotland, Dr John Crichton, and to local Training Programme Directors for Core Training.

3 ASSESSMENT

3.1 UNDERGRADUATE TRAINING

Teaching Programme for Edinburgh Undergraduate Medical Students

Day Visit

The State Hospital continued to deliver training to medical students in their 5th year during the academic year 2018/19 in the form of a one day visit incorporating clinical teaching in the morning and formal lectures in the afternoon. The lectures cover the civil mental health act and the more

specialised area of forensic psychiatry. There are six visits per academic year each comprising of approximately 50 students.

Feedback is sought from the students on the day for both parts of the teaching. The clinical teaching is mostly in the "excellent" domain, with a choice of "poor, average, good or excellent". The formal lectures feedback is very positive, with the amalgamated feedback from the lectures detailed below.

Did you find the lecture useful?

1 not useful	40 quite useful	86 very useful	----------

How was the presentation?

0 poor	6 okay	121 good	----------

Feedback from the small group teaching

0 poor	3 average	53 good	88 excellent

Clinical Attachment

In 2018/2019 there was a change in the arrangements for attachments of 4th year students. Previously the hospital had facilitated a two week clinical attachment for four groups of two students per year which was well attended and well received by students. Instead, the students had their six week attachments to a General Adult Psychiatry team organised ad hoc when they met with their tutor. Clinical attachments to specialties such as forensic and addictions are no longer part of the formal programme and are required to be arranged individually, on request. To try and pre-empt a decrease in students attached to TSH, the local tutors were contacted and offered a four day forensic programme during their attachment. There have been no requests for placements at TSH during this academic year.

The new system has caused issues all around. The specialties are no longer receiving students for attachments and general adult colleagues have found the system difficult to navigate. At the 2019 clinical tutors meeting it was unanimously agreed that there should be a return to the previous system. The two week attachment to TSH will restart when the programme reverts to its previous format.

Ad Hoc Attachments

Individual students from other medical schools in Scotland and from further afield contact the State Hospital directly on occasion for day visits or seeking elective placements for several months. We have the capacity to accommodate these requests. Students from Glasgow, Aberdeen, Dundee and Nottingham medical schools have visited this year.

Feedback

A report is provided to the Medical Advisory Committee yearly which gives the opportunity to discuss improvements to the teaching. Medical staff also have the option of requesting individual assessment of their teaching skills as part of the Clinical Educator Programme. To date, two staff have taken this up with positive results.

As undergraduate teaching lead Dr Billcliff attends the Edinburgh University Undergraduate Sub-Committee Meeting annually where feedback from each psychiatry placement is discussed. This year's meeting was focused on the unproductive changes to the teaching programme and the support for a return to the previous system that worked well for exposing students to high secure care.

3.2 POST GRADUATE TRAINING

Core Training

The past year has been a very positive one for our post graduate training, especially for our Core Trainee group. Normally we receive two Core Trainees from the West of Scotland Training Scheme and one from the East. This has been the case during each of the two six month blocks over the past year. In the first six months all of our Core Trainees were full time whereas in the second six month block one of our Core Trainees was less than full time (LTFT, 80%). Alongside our two non-training grade Specialty Doctors this meant that we had five Doctors on our first tier medical on call rota during the first six months, necessitating internal locum cover for the remaining slot in our one in six first on call rota. During the second six months we were fortunate in having a Specialty Trainee ST4 who elected to join our on call rota, thus enabling it to run on a one in six basis.

The recruitment climate for Core Trainees in Psychiatry remains challenging nationally and there is the continuing possibility we may not receive three Core Trainees from the West and East of Scotland Training Schemes as a result of vacancies there, thus leaving our first medical on call rota exposed. I understand that consideration is being given to recruiting an additional Specialty Doctor to bring our complement up to three. If it is possible to do so, this would put our first tier on call rota on a more secure footing.

The highlight of our Core Training over the past year has been the award of a Good Practice Recognition from the NES Mental Health Quality Management Group, not only for the current training year but also for the consistency of high quality feedback over a consecutive three year period. The Scotland Deanery Mental Health Quality Review Panel held on 11 September 2018 wrote to congratulate the Hospital on its achievements in relation to training in Core Psychiatry. It recognised the important, positive feedback from Doctors in Training about the quality of training and the training environment provided. In the National Training Survey for 2018 the State Hospital achieved 4 or more green flags (denoting top quartile) and the absence of any red flags. Green flags were achieved for clinical supervision out of hours, reporting systems, supportive environment, workload, team work and educational environment. Additionally, triple green flags in consecutive yearly data were noted for clinical supervision out of hours, supportive environment and workload. The good practice recognition letter is attached in Appendix 1.

Higher Specialty Trainees

Over the past year we have had seven Specialty Trainees attached to the State Hospital for periods varying from one week to six months, on either a full time or LTFT basis. Our Specialty Trainees work under the supervision of Consultant trainers, of which we have nine employed by the State Hospital, one of whom is currently working with the Scottish Government - see Appendix 2.

Specialty Trainees spend part of their weekly timetable undertaking research and special interest activities and overall generally spend less time at the State Hospital than Core Trainees and Speciality Doctors. Their role is distinct, represents a progression from Core Training and maintaining appropriate distinction in their role from those of other non-Consultant grade Doctors is important as they progress towards readiness for Consultanthood.

Senior Specialty Trainees in their final year of training can act up as a Consultant for a maximum period of three months. This has not occurred within the State Hospital during the last year.

In terms of the quality of training for our Specialty Trainees, the State Hospital has once again performed strongly. In the GMC National Trainee Survey the State Hospital has been in the top quartile nationally for workload, feedback and rota design. The results for the Scottish Training Survey and the GMC National Training Survey are attached in Appendix 3.

Teaching Programme

A series of six lectures is delivered by Consultant Psychiatrists to Trainee Doctors during the first three months of their placement at The State Hospital. The current programme encompasses six lecture topics which broadly cover the fundamentals of Forensic Psychiatry and related practice.

State Hospital Visits

Occasional requests for "taster visits" by Foundation Grade Doctors / Core Trainees / non-forensic Specialty Trainees continue to be received on a fairly regular basis. Generally speaking these Doctors are curious to find out more about Forensic Psychiatry and in some cases they have an interest in pursuing Forensic Psychiatry as a career. Over the past year one such request was facilitated in May 2019 from a Core Trainee working in NHS Lanarkshire.

Psychotherapy Training

We have part-time input from a Consultant in Forensic Psychotherapy, Dr Adam Polnay. He provides Balint / Reflective Practice sessions for non-Consultant Grade Doctors. Such work forms part of the Core psychotherapy training requirements and feedback for same has been positive. A summary of feedback from the Balint Group is included in Appendix 4.

GMC Recognition and Approval of Trainers (RoT)

Implementation of the GMC led recognition of secondary care trainers is now properly embedded and allows formal recognition of trainer status via the annual appraisal process of Doctors who have one or more of the following roles:

a) Named Clinical Supervisor in postgraduate training
b) Named Educational Supervisor in postgraduate training
c) Lead Co-Ordinators of undergraduate training at each local education provider
d) Doctors responsible for overseeing student's educational progress for each medical school

As shown in Appendix 2, the State Hospital is currently in a strong position with regard to recognition of trainers. Two of our Consultants have become Higher Specialty Trainers within the past year and we are well positioned with regard to our capability for providing training for Doctors in Forensic Psychiatry, Intellectual Disabilities and Psychotherapy.

NES Deanery Quality Management Visit

On 19 June 2019, the State Hospital received its first NHS Education for Scotland (NES) Quality Management Visit, chaired by Dr Amjad Khan, Lead Dean Director for Mental Health. I think it is fair to say that this visit was very positive, recognising many areas of good practice, including Trainee involvement in multi-professional learning, reflective practice, patient safety and quality improvement activities. Areas for improvement included two IT related items (delays in accessing IT systems at the start of placements and limitations on access to the internet / certain websites) and a suggestion that greater use could be made of handovers as learning opportunities. These issues have already been considered by the Training Committee on 22 July 2019 and will remain on these minutes to ensure progress is monitored. There was only one formal requirement from the visit, namely that colour coded badges should be introduced to enable the level of competence of Trainees to be evident to those that they come into contact with. This requirement was immediately implemented and was in place for the cohort of Trainee Doctors who joined us on 7 August 2019.

The NES visit also noted comments from trainee doctors expressing concern about the potential impact of forthcoming changes to Consultant's job plans resulting from the loss of the contracts to provide psychiatric input to a number of prisons in Forth Valley. This may have an impact on the availability of suitable training opportunities for postgraduate Doctors and could lead to a reduction

in the duration of placements of Specialty Trainees from other areas. It was however acknowledged this is an evolving situation and one which will require monitoring.

The feedback report from the NES Deanery Quality Management Visit is attached as Appendix 5.

Representation at External Committees Relevant to Medical Education

Dr Callum A MacCall represents The State Hospital and / or the National Forensic Psychiatry Training Programme at the following:

- West of Scotland Committee in Psychiatry
- National Forensic Psychiatry Specialty Training Committee
- Royal College of Psychiatrists Forensic Specialty Advisory Committee
- Royal College of Psychiatrists Curriculum Review Committee
- NHS Education for Scotland Annual Review of Competence Progression (ARCPs) for Forensic Higher Specialty Trainees
- Taskforce for the Improvement of Medical Education (TIQME)

4 RECOMMENDATION

The Board is invited to note the following:

i) The continuing high standard of undergraduate and postgraduate medical training provided within the State Hospital. Within the past year particular achievements have been the award of a Good Practice Recognition from NHS Education for Scotland and the very positive first Scotland Deanery Quality Management visit.

ii) The Hospital has a well trained and experienced Consultant workforce which has been strengthened this year with the addition of two new Higher Specialty Trainers. We are well positioned to continue to provide high quality training for medical students and postgraduate trainees in forensic psychiatry, intellectual disability and psychotherapy.

iii) The past year has shown improvements with regard to our overall levels of non-Consultant grade medical cover (Core Trainees and Specialty Doctors) however there have been points where our first tier medical on call rota has required internal locum cover. It is hoped that the possible recruitment of an additional Specialty Doctor (to bring our complement up to three) may put our first tier rota on a stronger footing going forward.

iv) The loss of contracts for the provision of prison mental healthcare in Forth Valley may have an impact on the availability of suitable training opportunities for postgraduate Doctors and could lead to a reduction in the duration of placements of Specialty Trainees from other areas. Hence the availability of opportunities for offsite working by our medical staff should be monitored.

Dr Callum A MacCall

Dr Callum A MacCall
Consultant Forensic Psychiatrist
Educational Supervisor

6 August 2019

Date of next annual report – August 2020
Date of next Board report – October 2020

Appendix 1

Professor Lindsay
Thomson Medical Director
National Facility

Date: 1st November 2018

Dear Professor Thomson

Recognition of important, positive feedback from doctors in training about the quality of training and the training environment in Core Psychiatry at the State Hospital, Carstairs

Following the Scotland Deanery Mental Health Quality Review Panel that was held on 11th September 2018, I write on behalf of the Mental Health Group to congratulate you and the trainers associated with training in Core Psychiatry at the State Hospital on the very positive feedback that trainees have provided on their experience of training.

The feedback that we have been particularly impressed with relates to:

NTS 2018 - 4 or more green or light green flags in a single year and absence of red flags. Green - Clinical Supervision Out of Hours, Reporting Systems, Supportive Environment, Workload, Teamwork and Educational Environment.

NTS 2018 - Triple green in consecutive yearly data - Clinical Supervision Out of Hours, Supportive Environment and Workload.

We appreciate your leadership of training for your Health Board, but also recognise the valuable contribution made by your trainers, and we are delighted to be able share our awareness of the positive feedback that we have received about the training you provide.

Yours sincerely

Professor Ronald MacVicar Lead Dean Director
Mental Health Quality Management Group

cc: Dr Claire Langridge; Associate Dean

Appendix 2

	NES Clinical Supervisor Course or equivalent	NES Educational Supervisor Course or equivalent	Named Medical Trainer Role	Forensic, Intellectual Disabilities+ or Psychotherapy++ Higher Specialty Trainer	Self-declared Recognition of Trainers (RoT) section of appraisal (or do you intend to do so at next appraisal)?
Duncan Alcock	Yes				Yes
Prathima Apurva	Yes				Yes
Natasha Billcliff	Yes		Undergraduate Supervisor	Yes	Yes
Ian Dewar	Yes			Yes	Yes
Jana De Villiers	Yes			Yes+	Yes
Sheila Howitt	CEP* Level 2		Undergraduate Supervisor		Yes
Khuram Khan	Yes	Yes		Yes	Yes
Callum MacCall	Yes	Yes	Postgraduate Supervisor	Yes	Yes
Jon Patrick	CEP* Level 2				Yes
Adam Polnay	CEP* Level 3			Yes++	Yes
Gordon Skilling	Yes			Yes	Yes
Nicola Swinson	Yes	Yes		Yes	Yes
Lindsay Thomson	Fellow HEA**	Yes		Yes	Yes

*CEP = Clinical Educator Program **HEA = Higher Educational Academy

Scotland Deanery
Director of Medical Education Report

Postgraduate Medical Education: Quality Report
Key to survey results

Scottish Training Survey (STS)

Key	
R	Low Outlier - well below the national benchmark group average
G	High Outlier – performing well for this indicator
P	Potential Low Outlier - slightly below the national benchmark group average
L	Potential High Outlier - slightly above the national benchmark group average
W	Near Average
▲	Significantly better result than last year**
▼	Significantly worse result than last year**
—	No significant change from last year*
	No data available
	No Data

** A significant change in the mean score is indicated by these arrows rather than a change in outcome.

GMC National Training Survey (NTS)

Key	
R	Result is below the national mean and in the bottom quartile nationally
G	Result is above the national mean and in the top quartile nationally
P	Result is in the bottom quartile but not outside 95% confidence limits of the mean
L	Result is in the top quartile but not outside 95% confidence limits of the mean
W	Results is in the inter-quartile range
▲	Better result than last year
▼	Worse result than last year
—	Same result as last year
	No flag / no result available for last year

Aggregated results have been provided where there are fewer than 3 responses in the current year's NTS survey and therefore no data is available. The aggregated RAG outcomes have been **generated by NES** using the 2017-2019 NTS data. They are not attributable to the GMC.

Site: State Hospital, Specialty: Forensic Psychiatry

GMC NTS (Trainee)

Level	Overall Satisfaction	Clinical Supervision	Clinical Supervision out of hours	Handover	Induction	Adequate Experience	Supportive environment	Work Load	Educational Supervision	Feedback	Local Teaching	Regional Teaching	Study Leave	Reporting Systems	Teamwork	Curriculum Coverage	Educational Governance	Rota Design	N
ST	W	W			W	W	W	L	W	G	W	W	W	W	W	W	W	G	4

Scottish Training Survey

Group	Clinical Supervision	Educational Environment	Handover	Induction	Teaching	Team Culture	Work Load	N
Core - Psychiatry								3
Core - Psychiatry (aggregated)	G —	W —	W —	G —	G —	L —	G —	8
Higher - Psychiatry								4
Higher - Psychiatry (aggregated)	W —	W —	W —	W —	W —	W —	W —	13

GMC Trainer Survey

Specialty	Overall Satisfaction	Work Load	Handover	Supportive environment	Curriculum Coverage	Educational Governance	Time for Training	Rota Design	Resources for Trainers	Support for Trainers	Trainer Development	Response rate
Forensic psychiatry												29%

Site: State Hospital, Specialty: Core Psychiatry Training

GMC NTS (Trainee)

Level	Overall Satisfaction	Clinical Supervision	Clinical Supervision out of hours	Handover	Induction	Adequate Experience	Supportive environment	Work Load	Educational Supervision	Feedback	Local Teaching	Regional Teaching	Study Leave	Reporting Systems	Teamwork	Curriculum Coverage	Educational Governance	Rota Design	N
Core	W -	W -	G -		W -	W -	W ▼	G -	W -		W -	G ▲	W -	W ▼	L -	W -	W ▼	G ▲	3

Balint Group for Junior Doctors – Summary of Feedback.

Description of Intervention

I facilitate a Balint group for junior doctors (trainees and specialty doctors) twice a month. The purpose is to provide a regular, safe and reflective space for doctors to reflect on staff-patient interactions, and to discuss and apply psychodynamic ideas into everyday work. This sort of reflective activity is recognized as being essential for the safe and sustainable running of forensic hospitals (Forensic Matrix Papers on Reflective Practice and Structured Clinical Care, 2018). Applied to the State Hospital, a related aim of the group is to make the State Hospital an attractive and supportive place for trainees and specialty doctors to work in. The group counts for Core and higher Trainees as part of their psychotherapy training requirements.

Background

A previous evaluation of doctors' experience of these groups in July 2016 was very positive. In order to see how the groups are currently perceived, the survey was repeated.

Method

In the last month of the 6 month placement a short questionnaire given to all doctors taking part in the Balint groups for two cohorts:

- Trainees or specialty doctors whose attachment was between August 2017 and January 2018 ('Cohort 1)
- Trainees or specialty doctors whose attachment was between August 2018 and January 2019 ('Cohort 2')

The questionnaire consisted of 7 questions scored on a 5-point Likert scale (1 = 'disagree strongly'; 5 = 'agree strongly') (see table 1). Higher scores indicate more positive responses. There is a final free-text question asking for 'any other comments'

Table 1 – questionnaire used

Disagree strongly	Disagree	Neutral	Agree	Agree strongly
1	2	3	4	5

1. The groups started and ended on time with no unexpected cancellations
2. I found the group to be a non-judgmental setting
3. I had the opportunity to contribute from my own experiences
4. The groups helped my understanding of interactions between patients and staff
5. The groups helped my understanding about the workings of teams and the institution as a whole
6. The groups have helped to process and manage my responses to situations
7. Please give an overall appraisal of the groups (for this question the options range from 1 'very unhelpful' to 5 'very helpful')

The option was given to either return anonymously via the medical secretary, or to return to me directly.

Results

All doctors on placements took part in the Balint sessions. 5 doctors were in Cohort 1 and 5 in Cohort 2. 1 doctor was in both cohorts. 1 doctor in the cohort 2 finished the placement before the questionnaires were given out. Therefore a total of 9 questionnaires were administered.

7 questionnaires were returned out of 9 administered. 4 were returned anonymously and 3 by email directly to me.

All questionnaire items were rated as 'agree strongly' by all 7 respondents, indicating consensus positive responses about the Balint groups. In addition, all respondents indicated they found the group 'very helpful' as an overall appraisal.

Free text comments were given by all respondents (Box 1). These were largely positive, describing the group as helping with understanding situations and processing feelings. One respondent mentioned the timing of the group was not ideal.

Box 1 – free text comments

'I have found the Balint group very useful, working at TSH is different to other settings I have worked for a number of reasons – patient group, offending histories, staff dynamics and politics. Having a confidential space to talk through experiences and better understand situations and dynamics has been extremely helpful!'

'I really value Balint Group, a high secure setting would be a difficult place to work at times if there was no outlet to discuss challenging feelings. Realising that colleagues have shared similar emotions or had similar experiences helps significantly.'

'I feel I didn't get along to as many of the groups as I would have liked due to other commitments/on-calls/leave etc. although I do appreciate that Mondays are the best day to have the group due to most people being in the hospital that day.'

'An excellent Balint group – one of the best I've experienced. Thank you very much.'

'Very helpful! Provides valuable insights. Dr Polnay is an excellent facilitator.'

'I've found it very useful being new to forensics.'

'I enjoyed having a mixture of core trainees and higher trainees. Always felt comfortable to speak openly and raise any issues I had.'

Conclusions

The feedback from the questionnaire suggests that participants in the junior doctors' Balint group continue to find the groups very helpful in terms of supporting understanding of patient-staff interactions they are part of, and in providing opportunities to process emotional responses associated with clinical work.

In terms of limitations, this is a basic questionnaire measure only. Whilst the highly positive score are encouraging, I also note the possibility of responder bias as the doctors knew the questionnaires would be analysed by the group facilitator. In addition, to make it easy for questionnaires to be returned, there was the option to return questionnaires directly to me. Finally, clearly a more in-depth method of assessment (e.g. the Reflective Functioning Scale (Fonagy et. al. 1998) or other paper based methods could add to the robustness of the method. However these would take up considerable time, and the purpose of the current evaluation was by contrast for a simple and achievable way of evaluating routine practice.

In summary, the junior doctor Balint group is well valued by its participants and appears to be helpful. Accordingly I will continue to run Balint groups for Specialty Doctors, and for Core and Higher Trainees as part of their training placements at the State Hospital.

Dr Adam Polnay
January 2019.

Scotland Deanery
Quality Management Visit Report

NHS Education for Scotland

Date of visit	19th June 2019	**Level(s)**	Core/Higher
Type of visit	Scheduled	**Hospital**	The State Hospital
Specialty(s)	Mental Health	**Board**	The National Facility

Visit panel	
Amjad Khan	Visit Chair – Lead Dean Director Mental health
Claire Langridge	Associate Postgraduate Dean – Quality
Daniel Bennett	Regional Associate Postgraduate Dean
Les Scott	Lay Representative
Dawn Mann	Quality Improvement Manager
In attendance	
Patriche McGuire	Quality Improvement Administrator

Specialty Group Information		
Specialty Group	Mental Health	
Lead Dean/Director	Amjad Khan	
Quality Lead(s)	Claire Langridge and Alastair Campbell	
Quality Improvement Manager(s)	Dawn Mann	
Unit/Site Information		
Non-medical staff in attendance	9	
Trainers in attendance	4	Inc Medical Director and Educational Supervisor
Trainees in attendance	6 (All trainees)	Core/Higher
Feedback session: Managers in attendance	Medical Director, Chief Executive and Educational Supervisor	

Date report approved by Lead Visitor	10th July 2019

1. Principal issues arising from pre-visit review

This is a scheduled visit as part of the Deanery's five-year plan to visit each unit delivering training within the quality cycle. The visit team will take the opportunity to gain a broad picture of how training is carried out within the department and to identify any areas of innovation or good practice for sharing more widely. The visit provides an opportunity for trainees and staff within the unit/department to tell the Deanery what is working well in relation to training; and also, to highlight any challenges or issues, the resolution of which could be supported by the Deanery.

The 2018 NTS data was positive for the State Hospital with the site receiving a letter of good practice from the Mental Health Specialty Quality Management Groups (SQMGs).

2.

2.1 Induction (R1.13)

Trainers: The panel were advised that due to the high security nature of the environment they provide a thorough induction programme for trainees which runs over the first 5 days of their placement. A variety of topics are covered including sessions on security, breakaway training, on call duties, systems training and PANNSS training. There are also sessions run by multi professional colleagues including introductory sessions from pharmacy, learning and development, research and clinical effectiveness. The trainees also get a tour of the site and health centre and an opportunity to attend the hub they will be based at and meet staff based there. We were advised trainees are also provided with a comprehensive induction manual at the start of placement. Trainees are asked for feedback following the induction and improvements are made accordingly.

Trainees: Trainees advised they had received a thorough induction to the site which included a tour and time on the ward. We were told they had faced delays in receiving their IT log ins, they have raised these concerns with the educational supervisor who advised this will be corrected for the next intake of trainees. It was also felt that due to the nature of the site there are a lot of forms to complete but there is some repetition of these and the same form is requested several times.

Non-Medical Staff: It was felt the induction was comprehensive and different areas were involved in delivering sessions at induction including staff from pharmacy, the clinical effectiveness team, nursing and the library.

2.2 Formal Teaching (R1.12, 1.16, 1.20)

Trainers: The panel were advised there is a 6-lecture local teaching programme in place which runs at the start of placement covering a range of topics relating to the functioning of a high security unit and different psychiatric conditions. We were advised attendance at local teaching is good and there is a lot of planning in place to ensure it is run at a time that is suitable for maximum attendance including for the next session a doodle poll. There is also a weekly journal club and case discussion meetings on a Monday which are multi-disciplinary and have internal and external speakers. Trainees have access to additional courses and learning for example the New to Forensic programme. All trainees are supported to attend regional training relevant to their training programme which is bleep free.

Trainees: Trainees confirmed they all had the ability to attend the local six-part lecture programme, weekly journal club and case discussions which they found useful. Trainees advised they have protected time to attend the appropriate regional training.

Non-Medical Staff: The panel were advised all staff attend journal club and it has a good level of attendance from trainees.

2.3 Study Leave (R3.12)

Trainers: The panel were informed there are no issues with trainees accessing study leave.

Trainees: Trainees advised they had no problems gaining study leave.

2.4 Formal Supervision (R1.21, 2.15, 2.20, 4.1, 4.2, 4.3, 4.4, 4.6)

Trainers: We were advised Dr MacCall is the educational supervisor for all higher trainees and core trainees will have an educational supervisor in their home area. We were informed trainees will be allocated an appropriate clinical supervisor depending on their hub location and placement, normally trainees work with the same two or three consultants and one of these will be their clinical supervisor. Normally the site would be informed by the trainee's home area if there are trainees coming where there are known concerns. All trainers at the site have had RoT training and have time in their job plans for their educational role. There are known issues with systems showing incorrect RoT information for trainers at the site and they would appreciate guidance on how to correct this.

Trainees: Trainees advised they had all met with their local supervisor approximately 3 times a year.

Non-Medical Staff: It was felt trainees always have access to support both during the day and out of hours. We were informed there are various policies and procedures in place to maintain safety and this could lead to trainees being over protected at times.

2.5 Adequate Experience (opportunities) (R1.15, 1.19, 5.9)

Trainers: Trainers advised they are aware of the curricula requirements for trainees and Dr MacCall is currently involved with the changes to the Forensic curriculum. The panel were advised that trainees work with two consultants and are able to attend clinics with these consultants for example prison clinics and community based forensic clinics. Due to the nature of the work trainees would not be running their own clinics and are there for experience only. The trainers felt the trainees get a good range of educational experience and have access to research opportunities and Balint group and as there is a health centre on site trainees are not expected to carry out routine tasks such as bloods and ECGs. We were told there are no known issues with trainees achieving their competencies. Trainees attend psychotherapy long and short cases in their home location and timetables are arranged to facilitate these, it would be beneficial if these were at the start or end of the day due to travel but accommodations are made.

Trainees: Trainees felt they would have no trouble achieving their competencies. Trainees appreciated the opportunity to attend prison-based clinics with consultants. It was raised that there were no opportunities to see emergency cases, but this was not viewed as a problem as these could be met whilst at other placements. It was felt there is a good balance between time spent developing as a doctor and activity with little educational benefit especially as there is a health centre on site.

Non-Medical Staff: Senior nursing staff advised nursing staff were involved in the trainee's induction program and they delivered a session in the teaching program.

2.6 Adequate Experience (assessment) (R1.18, 5.9, 5.10, 5.11)

Trainers: It was felt it is easy for trainees to achieve their assessments within the placement. We were advised that trainers had not formally benchmarked assessments against other trainers however due to the size of the site consultants have discussions regarding assessments and trainees normally get assessed by two different consultants.

Trainees: Trainees felt it was easy to complete their assessments and felt these were fair and consistent.

Non-Medical Staff: The panel were informed nursing staff were asked by trainees to contribute 360-degree feedback and are involved in patient/trainee simulation.

2.7 Adequate Experience (multi-professional learning) (R1.17)

Trainers: The panel were told the trainees have access to modules run by the School of Forensic Mental Health which are open to multi-professional learners. The weekly journal club is open to all staff and there are internal and external multi professional speakers.

Trainees: Trainees felt there were ample opportunities for multi professional learning including Balint group, Journal club and a hub based reflection group.

Non-Medical Staff: It was felt there are numerous opportunities for joint learning among trainees and non-medical staff including journal club, case base discussions, discharge planning, monthly hub based reflective practice sessions and quality initiatives like TSH 3030.

2.8 Adequate Experience (quality improvement) (R1.22)

Trainers: We were informed the site has a very engaged clinical effectiveness department who run a session during induction and encourage trainees to take part in projects and audits. We were given details of the recent TSH 3030 programme that encouraged teams to spend 30 minutes a day for 30 days thinking about quality improvement, this was all staff across the site and trainees were involved. There are also monthly quality improvement clinics.

Trainees: Trainees felt there were lots of opportunities to get involved in quality improvement projects and audit. We were told there is a very engaged and approachable clinical effectiveness team on site who run regular events to encourage staff engagement including quality improvement cafes and a monthly event webinar. We were told the clinical effectiveness team run a session at induction.

2.9 Clinical supervision (day to day) (R1.7, 1.8, 1.9, 1.10, 1.11, 1.12, 2.14, 4.1, 4.6)

Trainers: The panel were advised there is no formal way for staff to differentiate between the different doctors, but details of the trainees will be given to staff at the start of placements. We were told there is a duty rota in place, so trainees are aware of who to contact for support both during the day and out of hours. Most consultants work at other sites as well as The State Hospital, but admin staff have access to their electronic diaries and they are contactable by phone. Trainers were not aware of any instances where trainees had to cope with problems out with their competence. Trainers felt that due to the nature of the site it was a very paternalistic organisation and there could be a risk of the trainees being overly protected. Trainers try to encourage staff to go to trainees and not straight to the consultants. It was also mentioned that the trainers value the trainees 'fresh eyes' and are open to them making change suggestions as it prevents institutionalisation.

Trainees: Trainees advised they always have access to clinical supervision and know who to contact both during the day and out of hours. Trainees advised they have never felt they had to cope with problems out with their experience. It was felt that due to the nature of the site there is a potential for them to not getting enough exposure or responsibility but felt the consultants were conscious of this and ensured they still had access to experience. Trainees felt senior colleagues and non-medical staff at the site were approachable and supportive.

Non-Medical Staff: Non-medical staff advised they are introduced to staff at the beginning of placement and told if they are core or higher trainees. They were not aware of any instances where a trainee had to cope with problems out with their competence level apart from an occasion a trainee was called whilst on call for a medical issue, but this was raised and addresses.

2.10 Feedback to trainees (R1.15, 3.13)

Trainers: The panel were informed that due to the small size of the site trainees work closely with the consultants which it was felt allows for regular informal feedback and trainees receive structured feedback at weekly supervision sessions.

Trainees: Trainees advised they receive formal feedback at weekly supervision sessions and due to the small team receive informal feedback on a daily basis. They find the feedback constructive and meaningful.

2.11 Feedback from trainees (R1.5, 2.3)

Trainers: We were advised that **t**rainees are encouraged to provide feedback to their clinical supervisor or educational supervisor. The panel were informed there are 3 - monthly training committee meetings which all trainees attend which has a standard agenda item for trainees to provide feedback. We were given a recent example where a trainee had raised whether it would be possible to work from home due to the travel commitments of attending regional training.

Trainees: Trainees felt they have opportunities to provide feedback to trainers on the experience of their training through their clinical and educational supervisors and at 3 - monthly training committee meetings.

2.12 Workload/ Rota (1.7, 1.12, 2.19)

Trainers: Trainers advised core trainees work on the State Hospital rota currently on a 1 in 6 rotation. There have been several occasions recently where there have been rota gaps, but a locum is employed to fill these. The trainers advised it is a relatively quiet rota and trainees are not required to be on site as travel time is worked into calls. Higher trainees are not part of the site rota but occasionally ask to be added for experience and this is accommodated. The panel were told there are no known issues with the rota which impact training or patient safety, rota monitoring has recently taken place and the rota was compliant.

Trainees: Trainees felt the rota was manageable and had no implication on patient safety or their education. It was confirmed the rota is 1 in 6 and it's rare to get called on site after midnight.

Non- Medical Staff: Non-medical staff were not aware of any concerns relating to the rota and thought it was easy to interpret who was on call.

2.13 Handover (R1.14)

Trainers: Trainers advised there is a 24-hour security report in place at the site allowing everyone access to information regarding patients. On a Friday there is a weekend safety report meeting which all levels of staff attend and includes handover information for the weekend. A written report is generated from this meeting which all can access. We were advised there is a Monday morning pathway meeting where the weekend is discussed. It was felt by trainers that there are informal opportunities for learning from handovers.

Trainees: The panel were advised there is no formal day to day handover due to the nature of the work but as there is a small cohort they are confident anything important would be handed over. Trainees confirmed there is a pre-weekend safety meeting which all levels of staff attend to convey information. It was felt there are no formal opportunities for learning from the handovers.

Non-Medical Staff: The panel were informed there is a pre-weekend safety meeting that all staff levels would attend and has an element of handover involved. We were told there are morning MDT meetings on each ward Monday to Friday and nursing staff have an evening handover where the nurse in charge would provide a personal handover to the duty trainee if appropriate. It was not felt that handovers were used as learning opportunities.

2.14 Educational Resources (R1.19)

Trainers: Trainers advised there are ample computers for the trainees to access and a library in the learning centre with an experienced librarian.

Trainees: Trainees advised they have limited internet access at the site due to a combination of security and capability issues, this can prevent them from accessing Royal College information or booking onto courses.

2.15 Support (R2.16, 2.17, 3.2, 3.4, 3.5, 3.10, 3.11, 3.13, 3.16, 5.12)

Trainers: We were advised there is a 3 - monthly training committee meeting which all trainees attend and are able to feedback any concerns about their experience at The State Hospital. Trainers informed us there are regular consultant and specialty doctor's meetings where patient safety is a standard agenda point, medical advisory meetings with trainee representatives and patient related care would be discussed at Monday morning meetings which are attended by all levels of staff. The educational supervisor advised he would be made aware of any cases where a student is struggling and would link in with local educational supervisors, clinical supervisors and the specialty training committee (STC). We were told that if a trainee were struggling senior staff would link in with the occupational health team if appropriate or the PSU team within the Deanery.

Trainees: The panel were advised some trainees worked less than fulltime and the site had been accommodating regarding this. It was felt support would be available for those struggling with the job in any way and they would have no hesitation in seeking support.

Non-Medical Staff: The panel were advised staff would raise any concerns regarding a trainee with the appropriate consultant or supervisor.

2.16 Educational governance (R1.6, 1.19, 2.1, 2.2, 2.4, 2.6, 2.10, 2.11, 2.12, 3.1)

Trainers: We were informed the State Hospital as a specialty NHS board have a requirement to produce an annual report which is reviewed by the Board to ensure the quality of training within the site. The report includes information on GMC results from the National Trainee Survey and local feedback garnered from trainees on local teaching etc.

Trainees: Trainees advised they would raise quality concerns through Dr MacCall who would feed into the Board. The panel were advised there are trainee representatives at various meetings where the quality of education at the site was discussed.

2.17 Raising concerns (R1.1, 2.7)

Trainers: The panel were informed trainees are encouraged to raise concerns regarding patient safety either immediately to the nurse in charge or through their clinical supervisor at weekly sessions. If trainees had concerns regarding their education, it was felt these would be raised to the educational supervisor or at the training committee meeting.

Trainees: Trainees advised they would raise concerns regarding patient safety with their supervisor or through Datix. We were informed there is a policy in place where any staff member can call a clinical pause if they have patient safety concerns and the concern will be discussed by all staff in the hub.

Non-Medical Staff: It was felt there are a number of ways for staff to raise patient safety concerns including handovers, staff business meetings, patient safety meetings, whistle blower policy, debriefs and clinical pauses.

2.18 Patient safety (R1.2)

Trainers: Trainers advised that the safety of patients, staff and the public was integral to the function of the State Hospital. We were told there are routine systems in place to ensure the safety of patients including a morning safety briefing which includes clinical and security updates. Trainees are not involved in this briefing however there is a hub meeting attended by trainees following the huddle each morning and relevant info would be shared. Trainees receive a session on health and safety as part of their induction.

Trainees: Trainees advised they would have no concerns if a friend or family member were admitted.

Non-Medical Staff: Staff provided details of the sites safety report which holds details of the last 5 years' worth of adverse incidents including details of the category assigned, review outcomes and learning points. Staff can access this report online.

2.19 Adverse incidents (R1.3)

Trainers: The panel were advised that due to the nature of the site there are numerous systems in place to report adverse incidents including Datix. We were told there is a formal process in place were every Datix is reviewed in a timely manner by a member of the risk team who will identify any immediate learning outcomes and decide if a full review is required. The results of the review will be shared with the team however due to timescales of the review this can sometimes be after trainees have moved on. There would be a briefing immediately after an incident though and trainees would receive feedback on reported issues. All learning outcomes are also reviewed by management and published on the site's website, so all staff can learn from adverse incidents.

Trainees: Trainees advised they would raise adverse incidents through Daitx or a clinical pause. Trainees advised there would be a debrief following the event and depending on the incident a significant event review providing feedback.

Non-Medical Staff: It was confirmed there is a review following every Datix and a quarterly report is discussed at the clinical governance meeting. There will be a debrief following an event which will include relevant trainees and learning points are published for all to view once resolved.

2.20 Duty of candour (R1.4)

Trainers: The panel were informed there has recently been a site wide review of the duty of candour policy and this is published on their website, these will be updated in the induction pack for future trainees. We were told there is a weekly acute candour group which is multidisciplinary and a monthly review meeting to encourage an open and honest culture when things go wrong and the importance of apologising.

Trainees: The panel were advised there had been an occasion where a trainee was involved in a possible duty of candour concern, we were told it was thoroughly discussed among the team and an agreed response circulated when it was decided the issue fell out with the formal scope of the Duty of Candour process.

Non-Medical Staff: It was felt that as all clinical decisions about patients are made at a multi professional level this fosters close working relationships and a team culture. We were told there are site wide surveys carried out including questions on culture and behaviours and it was felt a significant amount of work is undertaken by senior staff to encourage a good environment and culture.

2.21 Culture & undermining (R3.3)

Trainers: It was felt that the small size of the site encourages a positive team culture as all staff were known by name and trainees work closely with consultants and multi-professional staff. We were informed there are

policies in place to prevent bullying and undermining including feedback from imatter surveys, training modules and a non-executive member of the board who can be confidentially contacted by any level of staff to report inappropriate behaviour. Trainers were unaware of any cases of trainees having received comments that were felt to be less than supportive.

Trainees: Trainees reported they had not witnessed undermining or bullying behaviour at any level during their placement. The panel were advised there are bullying and undermining processes in place and felt the senior staff at the site were very supportive.

Non-Medical Staff: Staff were unaware of any incidences of undermining or bullying behaviour and felt there is a positive team culture at the site.

2.22 Other

Trainees raised concerns regarding the cessation of prison clinics by the State Hospital following changes in the service provision back to certain health boards. It was felt that attending prison clinics with consultants was a valuable learning experience and trainees highlighted concerns regarding the implication on experience and workload for future trainees.

Trainees were asked to score their training experience from 0-10, the average score was 8 with a range from 7 to 9.

3. Summary

Is a revisit required?	**Yes**	**No**	**Highly Likely**	**Highly unlikely**

We would like to thank the site for their assistance in organising the visit and good attendance on the day. The panel were left with the impression of a supportive and approachable senior team with a focus on safety and training.

Please find below a list of positive and less positive aspects from the visit:

- Comprehensive induction including the extensive written manual
- Supportive and approachable consultants and senior team
- Strong focus on training for trainees including access to additional forensic courses
- Day to day opportunities for multi professional working and learning and trainee involvement in the MDT reflective hub group meetings
- Shared learning from adverse incidents including access to all incidents over 5 years with learning outcomes
- Emphasis on quality improvement and the visibility of the clinical effectiveness team including trainee involvement in initiatives such as the QI café and TSH 3030
- Focus on patient safety including the ability for any staff member within a hub to request a clinical pause where all staff will discuss the concern.

Less than positive:

- Trainees advised there were delays in accessing IT systems at the start of placement due to no system access.
- The panel recognised the high security nature of the site but there were limitations on internet leading to problems accessing educational sites i.e. Royal college sites and booking onto courses.

- The GMC have suggested the implementation of a colour coded badge system and posters to ensure all staff can identify the level of trainee and are aware of their competencies and supervision requirements.
- Handover could be used as a learning opportunity.
- Due to the nature of the work there could be a risk of trainees being overly protected and not having enough exposure or responsibility. The site seems aware of this concern and we would encourage them to continue this awareness.
- There is a period of change approaching where the prison clinics will cease. This could lead to uncertainty for trainees regarding experience and workload and we would encourage an open dialogue with trainees regarding this change.

4. Areas of Good Practice

Ref	Item	Action
5.1	Day to day opportunities for multi professional working and learning including trainee involvement in the MDT reflective hub group meetings and 9am MDT hub meetings.	
5.2	Focus on patient safety including the ability for any staff member within a hub to request a clinical pause where all staff will discuss the concern.	
5.3	Emphasis on quality improvement and the visibility of the clinical effectiveness team including trainee involvement in initiatives such as the QI café and TSH 3030.	

5. Areas for Improvement

Ref	Item	Action
6.1	Trainees advised there were delays in accessing IT systems at the start of placement due to no system access. We were advised this had been raised and taken on board.	
6.2	Handover could be used as a learning opportunity.	
6.3	Limitations on internet access leading to problems accessing educational sites i.e. Royal college sites and booking onto courses.	

6. Requirements - Issues to be Addressed

Ref	Issue	By when	Trainee cohorts in scope
7.1	The level of competence of trainees must be evident to those that they come in contact with. The use and promotion of colour coded badges as part of this must be introduced.	9 Months	All

8. DME Action Plan: to be returned to QIM on 15th August 2019

Ref	Issue	By when	Owner	Action(s)
8.1	The level of competence of trainees must be evident to those that they come in contact with. The use and promotion of colour coded badges as part of this must be introduced.	20th April 2019	The State Hospital	

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 August 2019
Agenda Reference:	Item No: 10
Sponsoring Director:	Security Director
Author(s):	Security Director
Title of Report:	Annual Report to Scottish Government on the Implementation of Specified Persons Legislation
Purpose of Report:	For Approval

1 SITUATION

The Mental Health (Care & Treatment) (Scotland) Act 2003, Section 286, makes provision for regulations (the regulations) relating to safety & security, use of telephones and correspondence. The Safety & Security Regulations place a duty on The State Hospital to furnish Scottish Government with an annual report on the implementation of the regulations. In the interests of openness and transparency, the annual report to the Scottish Government also includes information on the implementation of the regulations relating to correspondence and telephones.

The draft report for 2018 – 2019 is attached at Appendix 1.

2 BACKGROUND

The regulations are:

- The Mental Health (Safety & Security) (Scotland) Regulations 2005
- The Mental Health (Use of Telephone) (Scotland) Regulations 2005
- The Mental Health (Definition of Specified Persons) (Scotland) Regulations 2005

The regulations allow restrictions to be made relating to “Specified Persons”. The purpose of the specified person designation and related restrictions are to ensure the safety and welfare of the patient and others by allowing the Clinical Team to introduce managed and proportionate controls in defined areas. A system of reviews, reporting and appeals is also in place to safeguard the patient from excessive or disproportionate use of the specified person designation.

The specified person designation relates to:

- Correspondence
- Telephone calls
- Property and visitors
- Searching of patients and their property
- Searching of visitors and their property
- The taking of samples

- Surveillance of patients and visitors

Outside of the State Hospital the specified person designation is applied by the Responsible Medical Officer. The Act states that all patients at The State Hospital are automatically deemed to be Specified Persons due to their detention in The State Hospital.

3 ASSESSMENT

The report attached at appendix 1 is in the same format as previous years. It meets our obligation for an annual report. The data included in the report is regularly reported in more detail to the Board's Clinical governance Committee.

4 RECOMMENDATION

The Board is invited to **approve** the report for submission to the Scottish Government.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives?	Meets obligation for annual report to Scottish Government
Workforce Implications	None
Financial Implications	None
Route to the Board (Committee) Which groups were involved in contributing to the paper and recommendations?	SMT
Risk Assessment (Outline any significant risks and associated mitigation)	None
Assessment of Impact on Stakeholder Experience	None
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).	Not applicable
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One □ There are no privacy implications. X There are privacy implications, but full DPIA not needed □ There are privacy implications , full DPIA included.

Appendix 1

Annual Report to the Scottish Government Health Department on the Implementation of:

- **The Mental Health (Safety and Security)(Scotland) Regulations**
- **The Mental Health (Use of Telephones)(Scotland) Regulations 2005**
- **The Mental Health (Definition of Specified Person: Correspondence)(Scotland) Regulations 2005**

by The State Hospitals Board for Scotland for the period 1 August 2018 to 17 July 2018

1 THE HOSPITAL'S CURRENT POLICY ON SAFETY AND SECURITY

The State Hospital has 140 beds and is currently operating with 120. According to the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Act) all patients at The State Hospital are automatically deemed to be Specified Persons due to their detention in The State Hospital.

The State Hospital does not have a single "Safety and Security" Policy. Due to the intrinsic nature of security within a high security hospital, safety and security are a part of all policies and procedures. Areas in which policy exists that implement or are affected by the above regulations include:

- Patient mail and telephones
- Searching Patients
- Restricted and excluded items
- Restrictions on visitors
- Taking of samples
- Surveillance

Detail on these areas is provided below.

2 PATIENTS' MAIL AND TELEPHONES

Mail

The State Hospital Policy allows mail to or from the patient to be inspected and read by staff if individually prescribed by the Clinical Team. Mail can then be withheld from the patient or from being sent if it satisfies criteria related to safety or distress. As at July 2019 the patient numbers in the differing categories and instances of withheld mail were as below:

Incoming Mail Scrutiny	**13-14**	**14-15**	**15-16**	**16-17**	**17-18**	**18-19**
Opened in the presence of staff	39	48	35	31	28	23
Opened then inspected by staff	27	25	22	22	22	21
Opened, then inspected and read by staff	61	50	61	60	57	60

Outgoing Mail Scrutiny	**13-14**	**14-15**	**15-16**	**16-17**	**17-18**	**18-19**
Sealed by patient and handed to staff	25	34	24	22	19	17
Inspected by staff	33	35	27	24	24	22
Inspected and read by staff	69	54	67	67	64	65

Withheld Mail	13-14	14-15	15-16	16-17	17-18	18-19
Being sent by patient	1	2	0	0	0	2
Being sent to patient	1	0	0	3	7	0

Telephones

The State Hospital Policy allows outgoing calls from patients to persons approved by the Clinical Team. Under normal circumstances patients cannot take incoming calls.

Patients are either directly supervised by a member of staff who listens to the patient during the call, or indirectly supervised by a member of staff in the vicinity of the telephone. Technology and a new policy has been introduced which allows staff to hear both sides of the call and will allow recording of calls if deemed appropriate when the required technology has been introduced.

As at July 2019 the patient numbers in the differing categories were as below:

Telephone Call Supervision	13-14	14-15	15-16	16-17	17-18	18-19
All Supervised	53	45	59	57	49	52
All Unsupervised	53	56	34	30	22	20
Some Supervised	21	22	25	26	36	30

Calls to Advocacy, The Mental Welfare Commission, Legal Representatives and other persons listed in the Act are not to be supervised and do not require Clinical Team approval.

3 SEARCHING AND RESTRICTED OR EXCLUDED ITEMS

The State Hospital Policy allows the regular searching of:

- Patients
- Patients' rooms
- Patients' Lockers
- Patients' Visitors

Planned search frequencies are as follows:

Patient	Weekly
Locker	Weekly
Room	Monthly

Patients are also randomly searched when moving between areas, or if leaving an area where risk items are present that have not all been accounted for. An example of this would be when a patient needs to leave the dining room before cutlery has been counted.

In addition to these measures, to which every patient is subject, searches can be individually directed at a patient, his room or his locker based on information or presentation.

Policy also details those items that a patient is allowed in his room or is able to access. Items are excluded or restricted for a number of reasons, particularly the potential to cause harm or communicate with other devices and the internet. There are also overall restrictions on the quantity and volume of items to ensure rooms can be quickly and safely searched.

4 RESTRICTIONS ON VISITORS

The State Hospital Policy restricts patient visitors to those authorised by the patient's Clinical Team and restricts the items that can be brought into the Hospital by visitors. Policy also allows for Restricted Visits, in which 1:1 close supervision of the patient takes place.

The policy relating to Child Protection makes special arrangements to protect children who may visit patients or be present during Leave of Absence. Child contact requires special approval arrangements.

All visitors may be requested to submit to a search following entry through airport style security; all bags and other carried items are X-rayed and then searched if necessary.

5 TAKING OF SAMPLES

The State Hospital Policy allows the taking of oral fluid or urine samples to test for drugs of abuse. The majority of patients opt for an oral fluid test. The frequency of testing is between two weekly and annually as determined by the Clinical Team. The numbers of patients subject to each frequency as July 2019 is as follows:

Sampling Frequency	**13-14**	**14-15**	**15-16**	**16-17**	**17-18**	**18-19**
2 Weekly	21	24	23	29	15	15
1 Monthly	14	12	13	5	14	7
3 Monthly	20	13	18	17	17	16
6 Monthly	29	25	22	19	19	23
Annually	43	49	42	43	42	43

6 SURVEILLANCE

The Hospital operates a CCTV system around the perimeter, grounds and reception building of the Hospital, including areas of reception used by patient visitors.

CCTV is not currently used in clinical areas or to observe patients meeting visitors, though a business case has been approved that includes the introduction of CCTV to clinical areas.

7 POLICY REVIEW

The Hospital's policies and procedures are reviewed on a regular basis and as required.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 August 2019
Agenda Reference:	Item: 11
Sponsoring Director:	Director of Nursing and AHPs
Author(s):	Board Secretary
Title of Report:	Patient Safety, Infection Control and Patient Flow Report
Purpose of Report:	For Noting

1 BACKGROUND

This report is presented to the Board to provide an update in relation to patient safety, healthcare associated infection and patient flow.

2 PATIENT SAFETY UPDATE

The last patient safety meeting was held on 6 August 2019. The Patient Safety rolling 12 month report was presented to Clinical Governance Group on 7 August 2019 and will now be an agenda item at the August Clinical Governance Committee.

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

Improving Observation Practice (IOP) Workstream

- Awareness raising is ongoing within clinical teams
- Ongoing delivery of participatory learning sessions for nursing staff
- National observation policy template issued in June 2019
- GAP analysis completed for policy rewrite
- Short Life Working Group (SLWG) established to deliver policy rewrite by end of September
- Healthcare Improvement Scotland attending SLWG on 29 August
- Collaboration with Lead OT re hard to reach patients
- Case studies completed and shared following specific interventions from IOP lead
- Individual meetings with SCN's ongoing
- IOP now part of multi professional induction.

Communication at Transition

Patient Support Plans continue to be implemented for those on increased levels of observations, and for all new admissions. This is an individually tailored summary that highlights risk factors and interventions, and promotes person centred care. The key/associate worker is responsible for compiling the plan with patient input. This is reviewed and updated with the patient during their key worker 1-1 in advance of the weekly review.

Safer Medicines Management
The electronic PRN (as required medicine) form has been implemented across all wards. This remains subject to weekly checks. Site wide improvements have been observed with the completion of the e-form. This is now well embedded, and continues to be monitored by the Patient Safety Group. Iona 2 &3 have 100% completion of PRN recorded on RiO for the month of July.

Least Restrictive Practice
All Hubs have now had a formal introductory session with Dr Skilling and the Clinical Pause process is now live on RiO. All four Hubs have now held Clinical Pauses. It is anticipated that the process will continue to improve with ongoing PDSA cycles and feedback.

Dr Skilling has also presented Clinical Pause work at the National SPSP MH IOP leads meeting, and at the IHI/BMJ Annual Quality and Safety Forum (poster). Contact has been received from the three medium secure units in Scotland to request information on the Clinical Pause process. Information has also been shared with Broadmoor Hospital in the context of clinical model discussions here.

Leadership and Culture
Five walkrounds have taken place so far in 2019. Areas visited are Human Resources, Lewis 3, Mull 2, Mull 1 and Lewis 1. Actions and owners are discussed monthly at the Chief Executive Business meeting and the Patient Safety group.

Nationally, SPSP MH have launched new safety principles:

- Communication
- Leadership and Culture
- Least Restrictive Practice
- Physical Health
- Enablers

Work is ongoing to align our SPSP existing work with these new principles. For example, the Physical Health gap analysis has been shared with the Physical Health Steering Group to ensure a cohesive approach, and to avoid duplication of effort. The new safety principles, along with the existing policy review following the publication of From Observation to Intervention, are the focus of the group's priorities at the moment.

A presentation on tableau has been re-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, and the QI Forum. TSH presented the TSH3030 project at two recent national Patient Safety events in Glasgow and Edinburgh and have received requests for further information following this.

3 HEALTHCARE ASSOCIATED INFECTION (HAI)

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

Key Points:

- The submission 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. The Senior Nurse for Infection Control (SNIC) will continue to contact individual wards which are non-compliant to allow a late submission.

- The compliance within the Skye Centre continues to be of concern and the Infection Control Committee is working alongside Security and Estates to see if physical improvements to the location of hand gel dispensers can improve compliance.

- DATIX incidents continue to be monitored by the SNIC and Clinical Teams, with no trends or areas identified for concern with the exception of the Safe Management of Linen.

- 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 biennial audit is due to commence in November 2019. The Senior Nurse for Infection Control is now a member of the Hospitals Medicines Committee & Medication Incident Review Group.

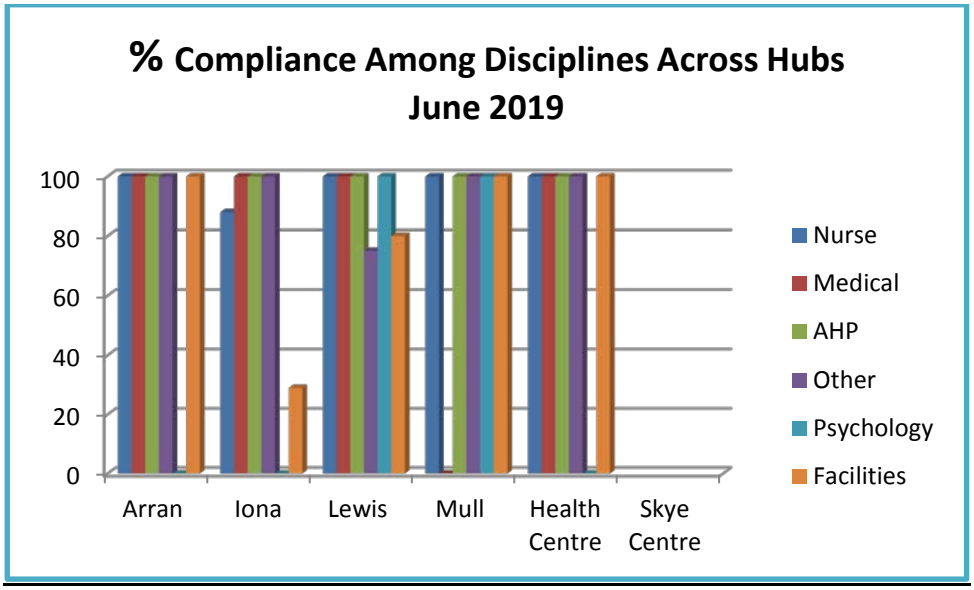
Audit Activity:

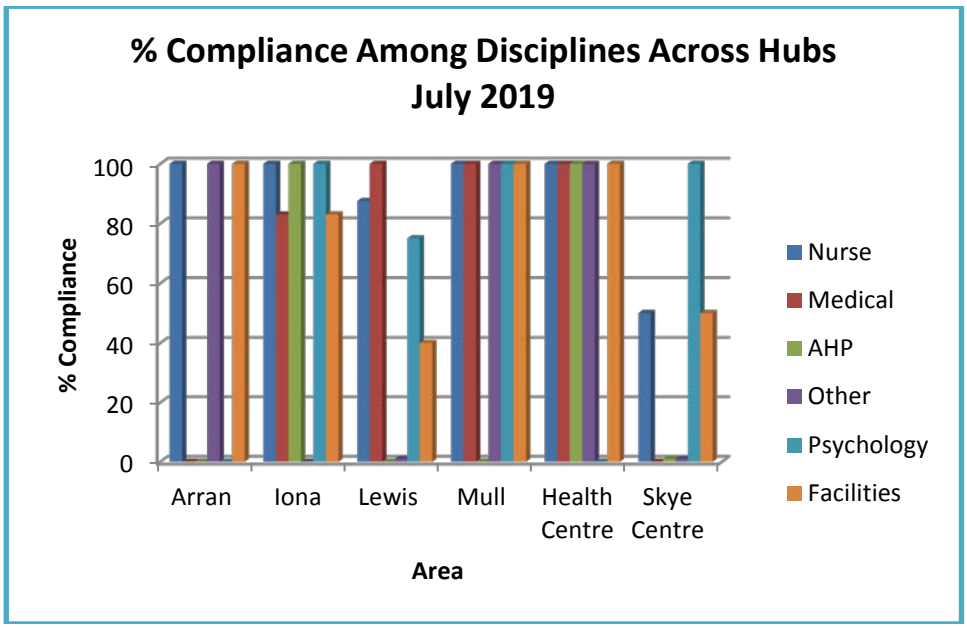
Hand Hygiene
During this review period, there was a drop in the number of audits submitted. Investigation shows that those responsible for undertaking the audits were on annual leave. Reminders to submit and follow up of non-compliance will continue to be carried out by the Senior Nurse for Infection Control.

June
11 out of a possible 12 were submitted

July
10 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 4% and health centre consistently attaining 100%. The Senior Nurse for Infection Control will undertake additional audits during the incoming months. The Charts below demonstrate the compliance among disciplines during the reporting period.





In order to improve the compliance rate within the Skye Centre the location of the Alcohol Based Hand Rub (ABHR) has been moved next to the screens. This seems to be a natural flow for staff exiting the building. The existing ABHR will remain in situ to provide staff with the option of using either dispenser. Skye Centre staff who are on 'door duty' will encourage staff to use the ABHR on entry and exit to the building and ensure that when possible this area is kept clear to aid compliance.

DATIX Incidents for Infection Control

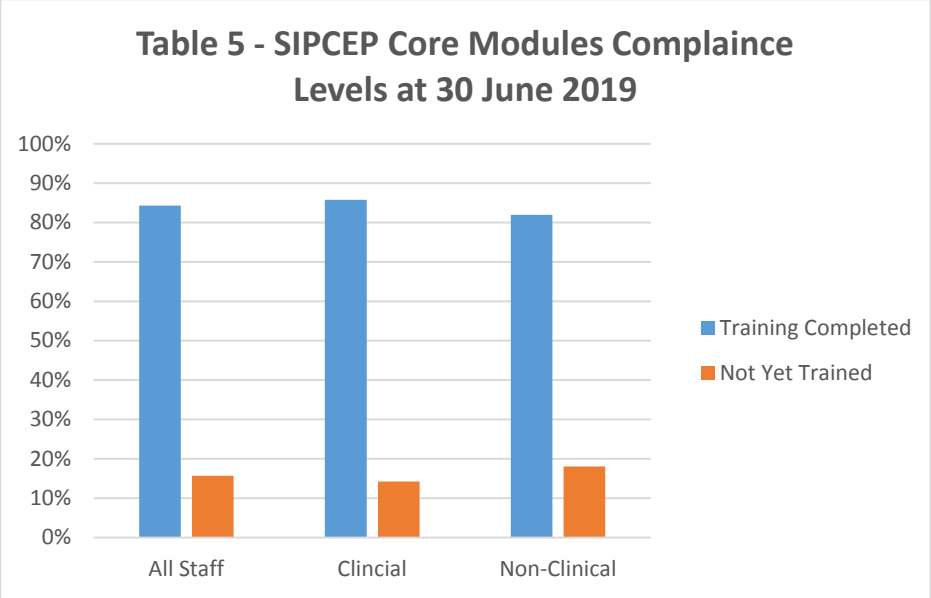
There were a total of 12 incidents for the period under the Category of Infection Control, all of which relate to clinical waste (safe management of linen). Staff are reporting that the laundry tags are falling off in the laundry cage; however this would not account for the misplacing of the red bags in the white hampers. These laundry tags are used by other NHS Boards. This is being investigated by the Senior Nurse for Infection Control, senior ward based nursing staff, and Risk Management.

There were 4 incidents recorded within the secondary category of Infection Control, 3 of which all related to 1 patient. This is being reviewed by the clinical team.

All Infection Control related DATIX incidents are investigated by the Senior Nursing Staff, clinical teams (as required) and reviewed by the Senior Nurse for Infection Control 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):

The SIPCEP implementation pathway was approved by the Infection Control Committee in August and by the SMT in September 2017. This has been added to the mandatory modules and is monitored by the Learning Development.



Core Modules	Advocacy	AHP	Arran 1	Arran 2	CE&R	Estates	Finance	F Network	Hotel Ser	House K
Target	6	15	29	29	9	25	8	5	18	58
Completed	5	13	23	22	8	16	8	4	18	52

Core Modules	Hub Adm	HR	I&E	Iona 1	Iona 2	Iona 3	eHealth	L&D	Lewis 1	Lewis 2
Target	20	6	2	29	27	29	12	10	32	33
Completed	15	5	2	25	25	24	9	10	28	30

Core Modules	Lewis 3	Mgt Cent	Medical	Med Rec	Mull 1	Mull 2	Nurse Dir	Nurse Pool	NPD	Ops Mgr
Target	28	13	14	3	27	28	5	10	4	5
Completed	24	10	13	3	25	24	5	7	4	4

Core Modules	OHS	Pharmacy	Procure	Psychology	Security	Skye	Social Work			
Target	4	7	7	24	44	33	10			
Completed	1	7	4	22	39	25	4			

Total	**Clinical**	**Non-Clinincal**
668	**408**	**260**
563	**350**	**213**
105	**58**	**47**
84.3 %	**85.8%**	**81.9 %**

Hepatitis C Treatment

1 patient is currently waiting on a second round of treatment. This has been outstanding for several months and is being progressed by our Finance Director in terms of funding for this treatment.

This will be discussed at the Medicines Committee and fed back to the Infection Control Committee in due course.

Policies and Guidance

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

4 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 June to 31 July 2019.

	MMI	**LD**	**Total**
Bed Complement (as at 31/07/19)	126	14	140
Staffed Beds (ie those actually available) (as at 31/07/19)	108	12	120
Admissions (from 01/06/19 – 31/0/19)	5	0	5
Discharges / Transfers (from 01/06/19 – 31/07/19)	10	0	10
Average Bed Occupancy June - July 2019	-	-	104 86.3% of available beds 74.2% of all beds

5 RECOMMENDATION

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

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	To provide the Board with specific updates 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 2 and 3 of report
Financial Implications	No financial implications identified
Route To Board Which groups were involved in contributing to the paper and recommendations.	Nursing and AHP Directorate/ Health Records – Board requested information
Risk Assessment (Outline any significant risks and associated mitigation)	Not identified for this report
Assessment of Impact on Stakeholder Experience	Not identified
Equality Impact Assessment	Not formally assessed
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	Not identified as relevant
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One √ There are no privacy implications. □ There are privacy implications, but full DPIA not needed □ There are privacy implications , full DPIA included.

Board Paper 19/58

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 August 2019
Agenda Reference:	Item No: 14
Sponsoring Director:	Interim HR Director
Author(s):	Interim HR Director
Title of Report:	Attendance Management Report
Purpose of Report:	To update the Board on attendance across the site

1 SITUATION

The State Hospital (TSH) sickness absence level in-month figure for May 2019 was 5.34%; with an average rolling 12 month figure of 7.52% for June 2018 to May 2019.

This is the lowest monthly level of absence in TSH in the last 5 years. The Board should note the local target level is 5%..

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 5.34% is the lowest in-month level recorded by TSH in the last 5 years. However, this does exceed the 5.0% target and the NHS Scotland level of 5.17% for the same period (Appendix IV).

Long/short term absence split is 4.38% and 0.96% respectively. These figures were recently recalibrated and therefore make comparison with historic data irrelevant. (Appendix II).

The in-month absence level equates to a loss of 4,096.28 /25.17 WTE..

The current average rolling 12 month sickness figure is 7.52% for the period 1June 2018 to 31 May 2019. This represents a lower figure than both previous years (2017/18 – 8.5%, 2016/17 - 8.35%). The current national target is to achieve 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 (36%), Musculoskeletal (13%) and Fractures (11%) (Appendix I).

4. RECOMMENDATION

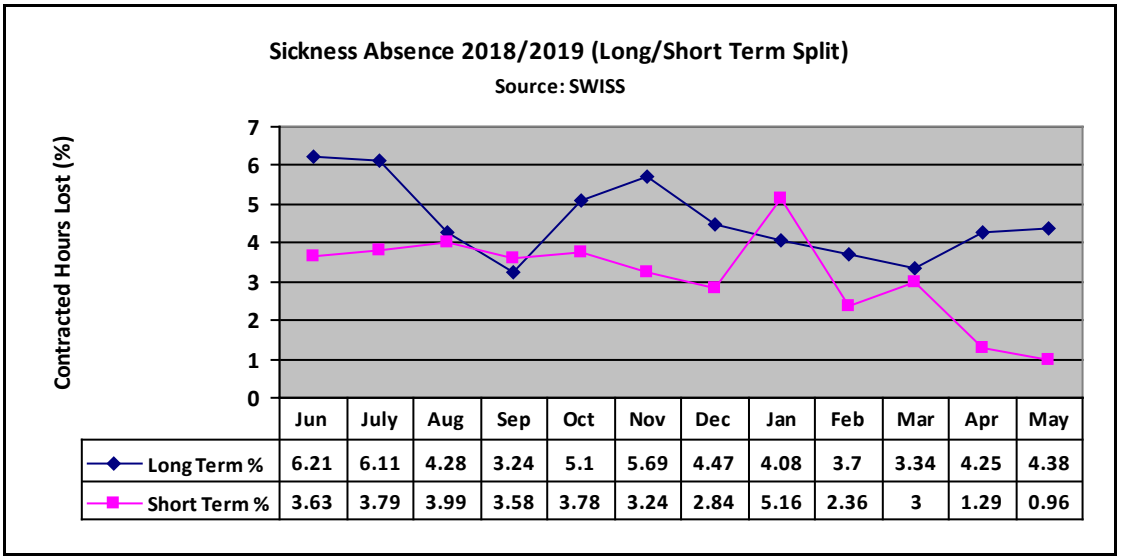
The Board is asked to **note** the content of the report.

Appendix I : Absence Reasons 1st June 2018 to 31st May2019

Absence Reason Description (1 June 2018 to 31 May 2019) Source: SSTS	Short Term Sick %	Long Term Sick %	Total (SL+II) Working Hours Lost	Total % inc Industrial Injury
Anxiety/stress/depression/other psychiatric illnesses	10.38 %	47.08 %	35348.39	36.37 %
Other musculoskeletal problems	6.66 %	8.53 %	12480.20	12.84 %
Injury, fracture	3.53 %	9.34 %	10362.77	10.66 %
Gastro-intestinal problems	19.03 %	3.77 %	6059.58	6.23 %
Back problems	8.53 %	5.25 %	5237.58	5.39 %
Cold, cough, flu - influenza	19.26 %	1.77 %	4730.79	4.87 %
Other known causes - not otherwise classified	4.94 %	4.66 %	4364.80	4.49 %
Genitourinary & gynaecological disorders - exclude pregnancy related disorders	2.24 %	5.39 %	4114.08	4.23 %
Heart, cardiac & circulatory problems	0.97 %	5.02 %	3627.98	3.73 %

Details all absences amounting to greater than 2%. Source: SSTS

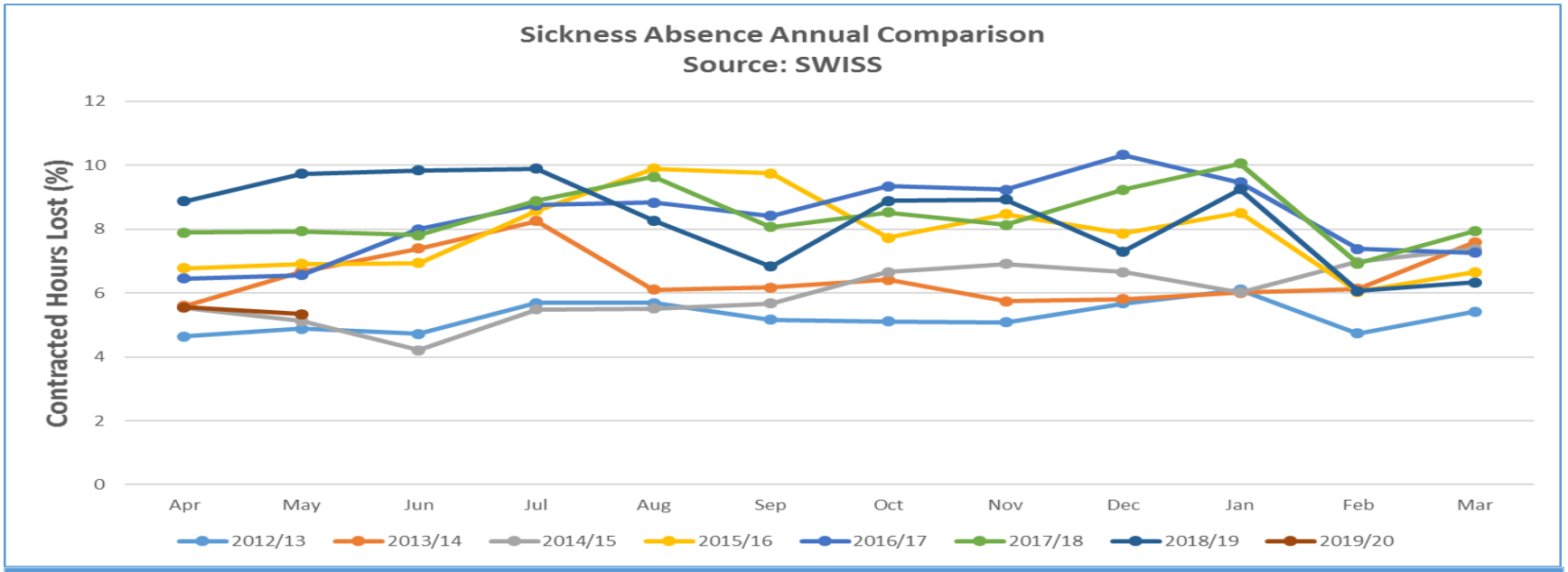
Appendix II : LONG / SHORT TERM ABSENCE BREAKDOWN – NATIONAL DATA (SWISS)



	Jun	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
Long Term %	6.21	6.11	4.28	3.24	5.1	5.69	4.47	4.08	3.7	3.34	4.25	4.38
Short Term %	3.63	3.79	3.99	3.58	3.78	3.24	2.84	5.16	2.36	3	1.29	0.96

Chart 1 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 2018 at 9.9%.



Year/Month	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
2019/20	5.55	5.34										

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

	Absence Rate			Instances			Absence Reason	
	Total	Long Term [1]	Short Term [2]	Total	Long Term [1]	Short Term [2]	Yes	No [3]
Scotland	**5.17**	**3.45**	**1.72**	**25,274**	**7,813**	**17,461**	**22,018**	**3,256**
NHS Ayrshire & Arran	4.84	3.29	1.55	1,408	460	948	1,274	134
NHS Borders	4.57	2.79	1.79	520	126	394	435	85
NHS National Services Scotland	4.45	2.91	1.54	509	137	372	491	18
NHS 24	7.80	5.21	2.59	424	130	294	365	59
NHS Education For Scotland	1.25	0.67	0.58	69	13	56	58	11
NHS Healthcare Improvement Scotland	3.43	2.37	1.06	53	15	38	47	6
NHS Health Scotland	2.24	1.22	1.02	32	5	27	28	4
Scottish Ambulance Service	8.05	5.98	2.06	840	366	474	800	40
The State Hospital	5.34	4.38	0.96	85	41	44	81	4
National Waiting Times Centre	4.48	2.81	1.67	257	83	174	231	26
NHS Fife	5.54	3.88	1.66	1,273	463	810	1,181	92
NHS Greater Glasgow & Clyde	5.54	3.91	1.63	6,156	2,243	3,913	5,499	657
NHS Highland	5.53	3.54	1.99	1,702	435	1,267	1,152	550
NHS Lanarkshire	5.56	4.09	1.47	1,669	667	1,002	1,433	236
NHS Grampian	4.46	2.56	1.90	2,454	529	1,925	1,958	496
NHS Orkney	5.09	2.78	2.30	107	23	84	101	6
NHS Lothian	4.61	2.64	1.97	4,058	955	3,103	3,586	472
NHS Tayside	5.10	3.51	1.60	1,859	596	1,263	1,645	214
NHS Forth Valley	5.49	3.82	1.67	893	317	576	825	68
NHS Western Isles	5.26	3.09	2.17	195	40	155	174	21
NHS Dumfries & Galloway	4.00	2.38	1.62	623	149	474	569	54
NHS Shetland	3.18	1.77	1.41	88	20	68	85	3

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 *SG(M)19/02*

Minutes of the meeting of the Staff Governance Committee held on Thursday 23 May 2019 at 9.45am in the Boardroom, The State Hospital, Carstairs.

Present:

Non-Executive Director	Bill Brackenridge ***(Chair)***
Employee Director	Tom Hair
Non-Executive Director	Maire Whitehead

In attendance:

Healthy Working Lives/EASY Manager – Salus	Gillian Archibald [Item 5]
Senior PMVA Trainer/Advisor	Lynn Clark [Item 12]
Board Chair	Terry Currie
Chief Executive	Gary Jenkins
Unison Representative	Anthony McFarlane
Clinical Operations Manager	Brian Paterson
Interim HR Director	Kay Sandilands
Board Secretary	Margaret Smith

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

Mr Brackenridge welcomed everyone to the meeting and noted apologies from Mr Nicholas Johnston and Ms Monica Merson.

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 HELD ON 17 AUGUST 2017

The Committee approved the Minutes of the previous meeting held on 7 February 2019 as an accurate record.

APPROVED

4 ACTION POINTS AND MATTERS ARISING FROM THE PREVIOUS MEETING

Members noted that each item either had been completed or was on the agenda for today's meeting.

NOTED

5 SALUS – EASY ANNUAL REPORT 2018/19

A report was submitted to the Committee for the EASY (Early Support for You) Service for 2018/19. Ms Gillian Archibald was in attendance to lead Members through the detail of the report.

The report demonstrated a high compliance rate for EASY, within The State Hospital (TSH). Absence trends demonstrated a high level of sickness absence for mental health issues, as well as injury/ fracture; and Ms Archibald suggested that the organisation may wish to focus further on these areas. She highlighted the case management service, especially in the context of mental health related absence, which had a low uptake rate within TSH, and how the service could be promoted with the aim of it being better used to support staff. Ms Archibald also suggested that the organisation may wish to seek further input for staff exceeding six months absence to consider appropriate supports going forward.

Members asked for further advice around the case management service, and Ms Archibald suggested that this could be taken forward through training sessions with line managers in order to raise awareness of the service. She also suggested that a case study from someone who had use the service and found it beneficial could be an effective way to promote it. This could be someone from either within TSH or outwith the organisation. Mr Jenkins advised that work was ongoing within Psychological Therapy Services (PTS) for further staff support, and this could be overlaid with this approach through Occupational Health. The Committee also asked about how training was delivered to line managers, especially in areas which could be difficult, such as support for women experiencing the menopause. Ms Sandilands suggested that HR could explore any areas line managers find challenging as part of the training sessions being delivered to line managers over July and August.

Action - Ms Sandilands

Ms Archibald noted that EASY provided additional data for the organisation over time, about reasons for absence. This could be especially helpful in TSH as a unique environment, allowing better benchmarking.

The Committee requested that absence rates for colds, coughs and flu, especially over long term absence, as well as gastrointestinal complaints. Ms Sandilands confirmed that this would be investigated further within HR.

Action – Ms Sandilands

The Committee thanked Ms Archibald for her attendance, and noted the content of the report.

NOTED

6 ATTENDANCE MANAGEMENT REPORT

The Committee received the Attendance Management Report for March 2019 and Ms Sandilands was in attendance to summarise the key issues. The absence rate was 6.34%, which represented a continued fall in the overall rate of absence.

Ms Sandilands advised that compliance with EASY had dropped slightly, and that it would be an area of focus to identify any hot spots for non-compliance across TSH.

The Committee noted the content of the report.

NOTED

7 ATTENDANCE MANAGEMENT IMPROVEMENT WORKING GROUP

Mr Jenkins provided the Committee with an update on the work of the task group which had met earlier in the week. He noted the work carried out by the group over time, and the effect this had on attendance management figures.

The aim was now to look further into the causes of sickness absence and the effect sickness absence could have on the organisation. The focus was on ensuring that TSH was an empowering and welcoming place to work, taking this wider focus on the culture, values and behaviours within TSH.

Mr Paterson advised Members that work was being taken forward to chart the impact of sickness absence to overtime across time, although staffing was influenced by a number of factors including clinical activity. Ms Sandilands added that further work would be progressed in this regards on the analytics around vacancies and recruitment.

The Committee noted the content of this report.

NOTED

8 HR PERFORMANCE – EMPLOYEE RELATIONS ACTIVITY

The Committee received a report, which provided an update on employee relations activity up to and including 30 April 2019. Ms Sandilands provided Members with a summary of the key data from the report.

Members noted national policy guidance was awaited, which also require local knowledge and skill in terms of implementation.

The Committee noted the content of the report.

Action – Ms Sandilands

NOTED

9 PERSONAL DEVELOPMENT PLAN REPORT

A paper was submitted to the Committee to provide a progress update in relation to personal development planning and review of staff governance standards and associated compliance.

The Committee was content to note progress made in this area.

NOTED

10 FITNESS TO PRACTICE

The Committee received a paper, which outlined the process for monitoring professional registration status at TSH, with the assurance that all members of staff held current professional registration.

The Committee noted the content of the report.

NOTED

11 VALUES AND BEHAVIOURS REPORT MARCH 2019

The Committee received a report from the Interim Human Resources Director as an update on the work of The Values and Behaviours Group in embedding the values of NHs Scotland into TSH. Ms Sandilands led Members through the report, underlining that it was helpful to take this review in the context of the Sturrock Report into NHS Highland.

Mr Currie agreed that this was a timely report, and should be considered alongside the self-assessment undertaken by the Board through the Corporate Governance Blueprint, which had highlighted the impact of culture and values and behaviours within the organisation.

The Committee asked for there to be particular focus on the visibility of Directors across the hospital. It was agreed that it was important that the engagement was meaningful for staff groups. Mr Currie added his agreement to this, and also emphasised the role that Non-Executive Directors could play through their presence at key events in TSH. There was discussion around how to put this into effect, on a practical level and Mr Jenkins advised that this would be taken forward through Organisational Development.

Action – Ms Sandilands

The committee noted that this meeting would include a fuller discussion of the recommendations in the Sturrock Report [Item 21]. Mr Jenkins suggested using the report as a baseline to help to lead change. This was a good opportunity to effect change especially on a single site hospital, and this would be taken forward through engagement with the workforce.

NOTED

12 STATUTORY AND MANDATORY TRAINING COMPLIANCE

The Committee received an update report on organisational compliance levels for statutory and mandatory training as at 31 March 2019. Ms Lynn Clark was in attendance to provide a summary of the key points. She highlighted the changes coming into effect at a national level this year as part of the Once for Scotland approach. It has been proposed that in future pay progression would be contingent of completion of statutory and mandatory training. The Committee considered this a positive change, but also noted that staff needed to be appropriately supported to undertake the training. Ms Clark advised that in TSH, the Learning Centre could be accessed at any time, to help staff to get access to online training.

Members asked for assurance on actions taken on non-compliance of mandatory training by line managers, and Ms Clark confirmed that a targeted approach was taken to this. Ms Sandilands added that line managers receive a monthly report on compliance levels for their teams.

Ms Sandilands advised the Committee that TSH had a wider framework of mandatory training than some other Boards, and it was agreed that a benchmarking exercise should be undertaken in this regard and a report brought back to this Committee

Members also asked for further assurance on non-compliance of core statutory training modules, e.g. manual handling, and asked that this was reviewed within the training department.

Actions – Ms Sandilands

The Committee noted the content of the report.

NOTED

13 IMATTER UPDATE – MARCH 2019

The Committee received a report on the 2018 cycle of iMatter for TSH, and Ms Sandilands provided a summary of the report for Members.

Members noted that there had been a drop in the completion of action plans**,** and the need to re energise the process for this year's cycle. Members asked the Organisational Lead to review what actions were taken by other NHS Boards with a view to improving the completion of Action Plans.

The Committee noted the report.

NOTED

14 STAFF GOVERNANCE ANNUAL MONITORING TEMPLATE

A report was received, requesting that the Committee approve the submission of the completed Staff Governance Monitoring template for 2018/19.

The Committee approved this, subject to minor amendment as well as noting the need to cross reference to the Corporate Governance Blueprint and to the Sturrock report.

APPROVED

15 EQUALITY DIVERSITY AND HUMAN RIGHTS ANNUAL MONITORING REPORT

A report was received, which completed a review of the hospital's equality data across the workforce profile, recruitment as well as employee relations and was presented to meet the Board's legal obligation to do so as part of the Equality Act 2010.

Ms Sandilands provided a summary of the report, and Mr Jenkins underlined that further focus would be brought to youth employment within the organisation in the coming year.

The committee noted the report.

NOTED

16 HEALTHY WORKING LIVES (HWL) STRATEGY – MAY 2019

A report was received to update the Committee on the HWL strategy and action plan for 2019/2022. TSH had achieved and continued to maintain the HWL Gold Award.

The Committee approved the Strategy Plan.

APPROVED

17 STAFF GOVERNANCE COMMITTEE – ANNUAL REPORT 2018/19

Members noted and approved the Committee's Annual Report for the year ended 31 March 2019, including the Terms of Reference.

APPROVED

18 NHS CIRCULARS

The Committee received a report, which summarised NHS Circulars PCS (AFC) 2019/02, 2019/03 and 2019/04 on attendance management, Appraisal and Incremental progression and Use of Time Off in Lieu.

It was noted that these had been discussed through the Partnership Forum and accepted.

The Committee noted this update report.

NOTED

19 HEALTH, SAFETY AND WELFARE COMMITTEE, DRAFT MINUTES - 15 JANUARY 2019

Members received and noted the draft minutes of the Health, Safety and Welfare Committee, which had taken place on 15 January 2019.

NOTED

20 PARTNERSHIP FORUM – MINUTES OF MEETINGS HELD 19 MARCH 2019

Members received and noted the minutes from the meeting held on 19 March 2019.

NOTED

21 ANY OTHER BUSINESS

Mr Jenkins introduced a discussion on the Sturrock Review into Cultural Issues related to allegations of Bullying and Harassment in NHS Highland, describing this as an opportunity to take a significant pause within the organisation. He advised that the Cabinet Secretary for Health and Sport had written to all NHS Boards requesting that they consider the report's recommendations and provide a response by 28 June 2019.

Mr Jenkins emphasised the need to engage as widely as possible throughout the organisation, as a conversation through the governance structure seeking different perspectives and the Staff Governance Committee was invited to provide their own views. Mr Hair, as Employee Director, would act as a focal point for feedback. Mr Jenkins added that this should be a bottom up approach led through engagement with and feedback from staff.

Mr Hair noted that he was also taking this conversation to union colleagues and this would also be valuable feedback.

Members discussed the difficulty of defining what bullying was, and how to remedy it. The focus should be on building up a culture of openness and conversation. Mr McFarlane added that day to day contact with the leadership team from the hospital could be very influential on the culture of the organisation as a whole. Mr McFarlane went on to say that it was important to understand that staff could adopt the culture they were employed into – and may not even realise that it was of a bullying nature if behaviours were accepted as the norm.

Members agreed and there was consideration of how to initiate and sustain direct links from the leadership of the hospital to wider staff groups. Leadership Walkrounds were noted to be useful in this regard, especially for Non-Executive Directors. Mr Hair also underlined his commitment to engaging with staff across the site, in his role as Employee Director.

This engagement would take place firstly with employees, with further consideration as to involving carers as well as patients.

This would also be added to the agenda of the next Board Meeting to take place on 20 June 2019, to support the Board's response to the Cabinet Secretary on 28 June 2019.

Action – Mr Jenkins/ Mr Hair

NOTED

22 DATE AND TIME OF NEXT MEETING

The next meeting would take place on Thursday 29 August 2019 at 9.45am in the boardroom, The State Hospital, Carstairs.

THE STATE HOSPITAL BOARD FOR SCOTLAND

Date of Meeting:	22 August 2019
Agenda Reference:	Item No: 16
Sponsoring Director:	Director of Finance and Performance Management
Author(s):	Head of Management Accounts
Title of Report:	Financial Position as at 31 July 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 July 2019, which is also included in the Partnership Forum agenda, the Board agenda and sent monthly to Scottish Government, with the financial template.

1.2 Scottish Government are provided with an annual Operational Plan (narrative plan – with a financial template forecast submitted for a 3-year period) which was confirmed at the 20 June 2019 Board meeting.

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 however a significant savings gap.
Confirmation by email was given from SG to capitalise the perimeter fence project facilitation / support staff, which is in the process of being confirmed and will help relieve the unidentified savings, since it is being funded from revenue just now (offset with increasing the savings gap). We have also currently assumed the reversal of the £0.127m tranche 2 saving for the territorial boards, which then reduced the unidentified savings. Employer's Sup'n is now adjusted in our Allocation, with a benefit of £0.060m taken to reserves, which should help some of the pressures noted in Table 2.2.

2 BACKGROUND

2.1 Revenue Resource Limit Outturn

The annual budget of £37.248m is primarily the draft Scottish Government Revenue Resource Limit / allocation, and anticipated monies.

The Board is reporting an under spend position of £0.047m to 31 July 2019, the table below shows analysis by expenditure type.

July 2019 movement £0.038m underspend. Nursing overtime is down again this month, although still overspent to date. Utilities is under spent in month.

Spend Type	Annual Budget £'k	Year to Date Budget £'k	Year to date Actuals £'k	YTD Variance (budget less actuals) for period 4	Budget WTE	Actual WTE (volume)
Other Operating Income	(582)	(194)	(210)	16	(2.00)	(2.00)
Pay	31,514	10,179	10,163	16	621.32	623.21
Savings	(1,629)	(76)	0	(76)	0.20	0.00
Purchase Of Healthcare	797	250	241	8	0.05	0.00
Non Pay	4,894	1,609	1,525	84	0.00	0.00
Hch Income	(603)	(264)	(255)	(9)	(9.07)	(9.22)
Capital Charges	2,857	952	945	8	0.00	0.00
	37,248	**12,456**	**12,409**	**47**	**610.50**	**611.99**

2.2 The table below highlights areas of key pressures / expected benefits to be received.

PRESSURES	Risk	Best estimate £'k
Holiday Pay (& possible retrospection) - Locke v British Gas	High	130
Rebandings arrears	High	tbc
Clinical Model Review	High	tbc
Legal Fees	High	80
EU Exit (may get guidance from sub group)	Low	tbc
Perimeter Fence - FBC - Additional Staff (Capital pending)	Low	193
3 yr up for opt out sup'an Nov 19 (approx 100 staff not sup'an)	Med	
BENEFITS	**Risk**	
Exceptional Circumstance Patients (new - recharging host Board)	Low	290
VAT element on Utilities in our favour (v HMRC)	Low	120

2.3 **Forecast Outturn**

The forecast outturn trajectory was an over spend of £0.150m, however the position is £0.047m underspent, therefore a favourable movement of £0.197m.
Unidentified savings are phased to month 12; therefore, there is the requirement to recognise an apportionment for the year to date.

HMRC has settled in our favour to reduce VAT on utilities to 5% from 20%, this windfall will benefit TSH in 2019/20 – for which the Electricity should be concluded July (there has been a delay due to VAT recognition on the invoices and credit notes), and we are awaiting detail re Oil and Gas.

We have been informed that arrears for one year will be funded from SG for the Locke v British Gas, but we will have to fund from 1st April 2018, we have a reserve set aside for 2019/2020 but unsure if until we have enough for both years until clarity on the payments.

A year-end breakeven position was forecast in the Operational Plan, pending outcomes on a number of pressures (most significant noted in the above table at 2.2).

3 ASSESSMENT

3.1 YEAR TO DATE POSITION – BOARD FUNCTIONS

Directorates	Annual Budget 19/20 £'k	YTD Budget July 19 £'k	YTD Actuals July 19 £'k	YTD Variance (budget - actual) (adverse) / favourable July 19 £'k	Budget wte	Actual WTE
Cap Charges	2,857	952	945	8	0.00	0.00
Central Reserves	109	59	16	43	0.00	0.00
Chief Exec	1,849	614	606	9	22.45	21.73
Finance	2,844	985	992	(8)	37.53	34.72
Human Resources Directorate	825	275	278	(3)	13.38	13.38
Medical	3,763	1,193	1,149	44	35.18	32.34
Misc Income	(294)	(98)	(15)	(83)	0.00	0.00
Nursing And Ahp's	19,397	6,466	6,455	10	378.53	377.66
Security And Facilities	5,898	2,010	1,982	28	123.63	118.56
Under / (over) spend	**37,248**	**12,456**	**12,409**	**47**	**610.70**	**598.39**

Key Highlights

Central Reserves – Charges are for non-AFC pay awards pending.
Finance – legal fees pressure, invoices exceptionally high to date for this year (pressure re specific cases).
HR – Occupational Health – pressure from backdated invoicing for 18/19.
Medical – Pressure in invoices from other Boards for Senior Trainee Doctors. **Psychology** – 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 4	Budget WTE	Actual WTE
Advocacy	147	49	49	0	0.00	0.00
AHP's & Dietetics & SLA'S	645	215	208	7	12.83	12.36
Hub & Cluster Admin & Clinical Operations	809	270	262	7	23.17	20.93
PCI & Pastoral	219	73	60	13	3.40	2.40
NPD & Infection Control & Clin Gov	429	143	127	16	5.80	4.99
Skye Centre	1,720	573	487	86	38.33	33.80
Ward Nursing	15,427	5,142	5,262	(120)	295.00	303.18
Total Nursing and AHP's	**19,397**	**6,466**	**6,455**	**10**	**378.53**	**377.66**

Key Highlights

Skye Centre – has a considerable number of vacancies.
Ward Nursing – Further detail in table below.

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
Total April 19		1,286	1,350	(65)	295.00	318.77	289.30
Total May 19		1,286	1,343	(58)	295.00	315.33	289.30
Total June 19		1,286	1,282	3	295.00	309.54	286.30
Total July 19		1,286	1,286	(1)	295.00	303.18	288.28
Cum July 19	15,427	5,142	5,262	(120)			
				(120)			
Variance analysis:							
Overtime for vacancies backfill				(123)			
Phased savings (not yet realised)				(50)			
Requiring further investigation by Nursing Resource				54	*		
				(120)			

3.3 **Further detail on Security and Facilities**

Security & Facilities	Annual Budget £'k	Year to Date Budget £'k	Year to date Actuals £'k	YTD Variance (budget less actuals) for period 4	Budget WTE	Actual WTE
Facilities	4,234	1,431	1,386	45	83.86	76.29
Security	1,627	542	560	(17)	39.77	38.87
Perimeter Security	37	37	37	(0)	0.00	3.40
Total Security & Facilities	5,898	2,010	1,982	28	123.63	118.56

Key Highlights

Facilities – Estates: Repairs spend, held back March 19, funded this year, also vacancies. Housekeeping: under spend re ward closures.

Security – Backfill pressure and acting post.

Perimeter Fence - revenue staff have been 'funded' by increasing the unidentified 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 July 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	25	25	(22)	(70)	(91)
Drugs & Prescribing	0	(20)	(20)	0	11	11	0	(9)	(9)
Workforce	(57)	(481)	(538)	15	256	271	(42)	(225)	(267)
Procurement	0	0	0	0	0	0	0	0	0
Infrastructure *(e.g.facilities mgt, IT, other support services)*	(56)	(309)	(365)	0	15	15	(56)	(294)	(350)
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	152	152	0	(813)	(813)
Total In-Year Efficiency Savings	**(134)**	**(1,969)**	**(2,103)**	**15**	**459**	**474**	**(119)**	**(1,510)**	**(1,629)**
Trajectory (1/12ths of LDP)				**45**	**656**	**701**			
(under) / over achieved				**(30)**	**(197)**	**(227)**			

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

As at July 2019	Savings - Annual Target	Achieved to date	(Still to be achieved) / over achieved
Directorate	**£'k**	**£'k**	**£'k**
Chief Executive	(162)	75	(87)
Finance	(99)	18	(81)
Nursing & AHP's	(261)	106	(155)
Human Resources	(33)	10	(23)
Medical	(117)	63	(54)
Security & Facilities	(367)	50	(317)
Unidentified (may offset contingency reserve if not required)	(100)	0	(100)
Unidentified	(965)	152	(813)
Total	**(2,103)**	**474**	**(1,629)**

Targeted saving 33%, actual saving 22%, underachieved 11%.

5 CAPITAL RESOURCE LIMIT

Capital allocation from Scottish Government is £0.269m.

Plans greater than resources need to be prioritised to bring projected expenditure back in line with the allocation.

	Annual Plan £'k	YTD Plan £'k	YTD Actual £'k	YTD Variance £'k
Estates	114	30	30	-
IM&T	105	75	75	-
Vehicles	50	-	-	-
Other equipment	-	-	-	-
Security Fence Dvpt	-	15	15	-
TOTAL	**269**	**120**	**120**	**-**

6 RECOMMENDATION

6.1 **Revenue: Under spend of £0.047m year to date. Year-end projection: Breakeven.**

Overtime in Nursing is still higher than budget year to date, however in comparison to previous years there is much improvement, and with many measures in place it is hoped to stabilise over the remaining months.

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.

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

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.

Board Paper 19/60

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 August 2019
Agenda Reference:	Item No: 17a
Sponsoring Director:	Director of Finance and Performance
Author(s):	Head of Corporate Planning and Business Support
Title of Report:	Update on Strategic Review of Performance
Purpose of Report:	Update Board on progress

1 SITUATION

The State Hospital has developed an Annual Operating Plan 2019 – 20, this plan replaces the previous Local Delivery Plan. The State Hospital's performance targets are aligned with the three quality ambitions in the national NHS Scotland Healthcare Quality Strategy; person centred, safe and effective. There is a need to review the current performance management framework to ensure that we are using the performance management cycle to support continuous improvement and have performance measures in place that provide effective monitoring towards achieving organisational outcomes.

2 BACKGROUND

The State Hospital has reported on a range of targets and key performance indicators, which have been nationally or locally set. Whilst there remains the requirement to report on and measure specific national targets, some the NHS Scotland's targets do not fit into the unique care environment provided by The State Hospital. There is an opportunity for hospital to strategically review its performance management framework and report data to assure the Board that it is measuring and reporting on the key priorities for the organisation. The Risk, Finance and Performance Group requested that a task group be established to progress a strategic review of performance management. This group met in November 2018, January 2019, March 2019 and again in May 2019.

3 ASSESSMENT

A performance framework and the associated measures demonstrate the progress towards delivering our strategy for improving the quality of patient care and organisational effectiveness. Performance measures are not an end in themselves but are a proxy measure for a wider system change. Data and measurement are key aspects of performance management and staff should be engaged in all aspects of performance management and measurement to encourage ownership of the data and outcomes.

To inform the strategic review of performance management a performance measurement scoping activity was carried out by the Task Group to review current position and future ambition for a performance management framework. From this scoping exercise the group noted:

What do we want for the future in terms of a performance monitoring framework?

- Clear escalation route for data for KPI's.
- Clarity on the scope and prioritisation of KPI's.
- Operational definition of KPI's so that we have clarity on what they are and their associated data sources.
- Clarity of governance and how the data collected for KPI's links to strategic objectives and operational priorities.
- Clarity of who are the KPI owners and what authority and responsibility they have for progressing measures

Key points for any new performance management system

- Communication is central to engaging people across the site and providing clarity on what we are doing
- Need to make the performance framework tangible for people so that can see how they link into it and what their role is
- Need to have a tone of improvement through performance – not punitive approach to targets and indicators, which can be perceived as blaming people if progress not made.
- Ownership of KPI and links form these to strategic objectives and operational priorities
- Clear explanation of why we measure what we do and clear operational definitions of our targets and measures
- Links between data collection and changes to practice as a result of what this tells us.

The Performance Management Task Group used the Strategic Objectives within the Strategy Map (appendix 1) as a structure to develop logic models for key organisaitonal priorities. The draft logic models identify the range of work ongoing and the data collected within the hospital that can act as measures or indicators of performance and will support the identification of key performance indicators. Further development of the models and detailing of indicators is required to ensure there is clarity on the operational definition of each indicator.

The Performance Management Group also identified the importance of the interface between its work and that of the 3 key Tableau Working Groups. There is cross over with each of the Tableau working groups to ensure active links between these two work streams. The linked logic models and tableau groups are noted below.

Performance Management Group Logic Model	Tableau Working Group
LM1: Staff attendance and Resilience	Patient Acuity and Dependency grp
LM2: Physical Health	Physical Health and Activity grp
LM4: Staff right place at the right time	Workforce Utilisation grp

Logic Model 3: Embedding a culture of continuous quality improvement and quality assurance to deliver excellent care; will be directly linked into the hospital Quality Improvement Forum.

There is a need to ensure benchmarking of our performance framework against similar organisations to ensure that we learn from examples of good practice that already exist. A balanced scorecard approach is regularly used across NHS Scotland and this is being explored as a potential structure for The State Hospital to adopt.

Next steps

- Develop a structure for the performance framework that represents a balanced scorecard approach to performance monitoring and reporting

- Benchmarking the range of KPIs, and associated measures identified with similar processes conducted within NHS Scotland and the English High Secure Counterparts

- Continue to link the work of the Performance Management Group with the work ongoing within each of the 3 Tableau working groups given their direct alignment to the areas of performance addressed within three of the PM group Logic Models. It is crucial that the two work streams are linked to prevent duplication of work, but also to ensure that the expertise available to each group are supportive of both work streams.

- Developing a matrix to collate the wide range of data measures available for each performance indicator. The range of measures then need to be distilled down through an appraisal process to define the most appropriate measure for each KPI. The focus should be on the best indicator and not data availability with issues of availability and consistency addressed as a secondary stage.

- Consultation with clinical groups and other relevant data owners to ensure the KPIs identified are considered appropriate measures of performance across all areas of the organisation. The Performance Management Group membership is aimed at ensuring multi-disciplinary representation.

- Consideration given to stratifying the data being utilised and presented across the hospital to ensure that the right groups have the rights data to support their function e.g. governance, organisational planning and performance, service planning, performance monitoring and evaluation, patient care level of decision making.

4 RECOMMENDATION

The Board is invited to note the progress made by the Performance Management Group on the Strategic Review of Performance Management, provide ongoing support and advise on the development of the performance framework

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	The Strategic Review of Performance will link directly to organisational strategy and corporate objectives.
Workforce Implications	No financial implications if approved
Financial Implications	No financial implications if approved
Route To Board Which groups were involved in contributing to the paper and recommendations.	Risk Finance and Performance Group
Risk Assessment (Outline any significant risks and associated mitigation)	No risk assessment required at present
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.

Appendix 1

The State Hospital Strategy Map 2018 – 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

Date of Meeting:	22 August 2019
Agenda Reference:	Item No: 17b
Sponsoring Director:	Finance and Performance Management Director
Author:	Head of Corporate Planning and Business Support
Title of Report:	Performance Report Q1 2019/2020
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 Q1 April - June 2019. A summary table and run charts for the performance indicators may be found in Appendix 1. We have added Q4 red, amber, green data to this table to give some trend data.

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.

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

We have maintained good levels of performance in many areas but performance in the following areas merit comment:

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

On 30 June 2019 there were 105 patients in the hospital. Ten of these patients were in the admission phase. 7 CPA documents had not been reviewed within the 6 month period. All 7 were out of date (uncertain currently of reasons – being checked with relevant staff). This gives a compliance of 92.6% which is a drop from December's 96.1% compliance. This indicator has moved into amber.

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 3 Patients will be engaged in off hub activity centres

For Q1, 83% of patients were involved in off-hub activities. This is a slight increase on last quarter (Q3 82%). This increase is due to new admissions being approved by Clinical Team to attend activity at the Skye Centre.

This percentage doesn't include patients planned to attend the hospital shop, patients scheduled to attend the Health Centre or those who regularly attending the Café Area. This means that patients engaging in off hub activities remains in the amber zone.

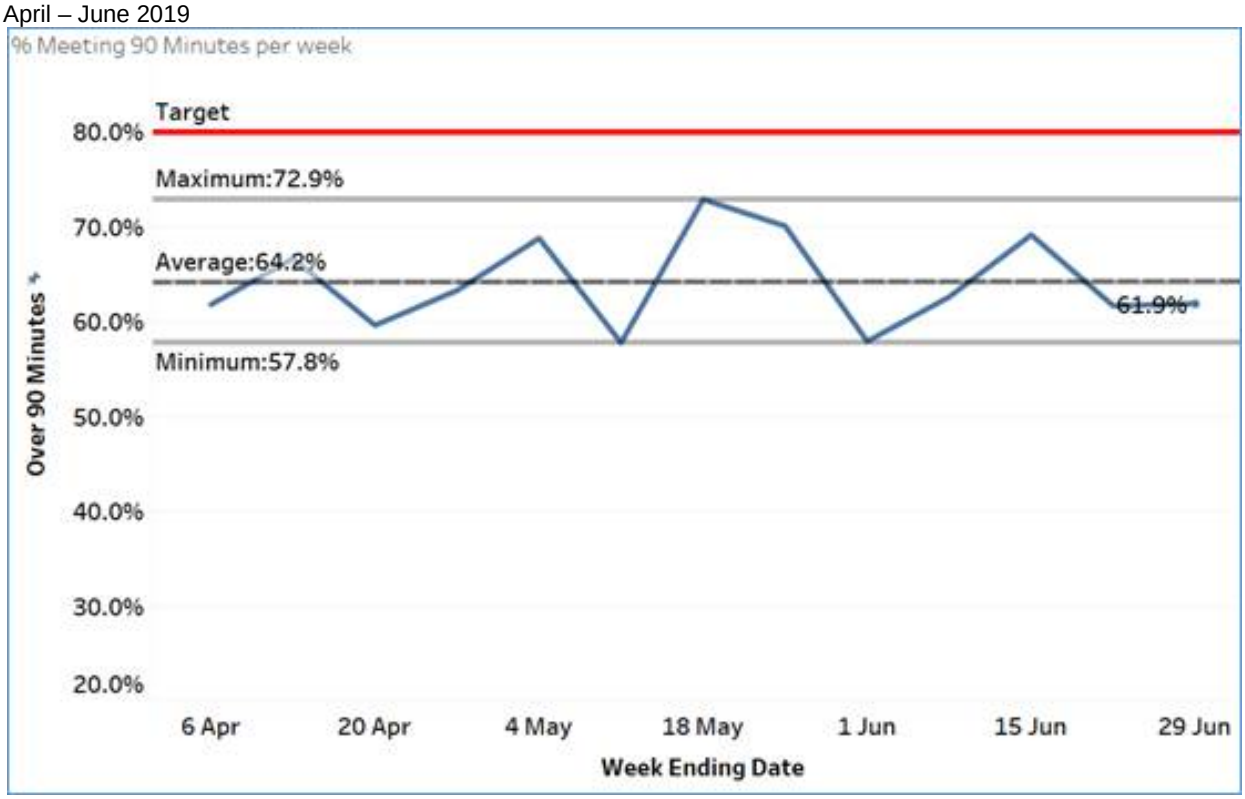
No 5 Patients will undertake 90 minutes of exercise each week

The Physical Activity levels over the first quarter have averaged 64.2%. This is an increase from 59.3% in the last quarter. The Physical Health Steering Group are currently reviewing data over the last year to look at trends and possible ways of improving the uptake of Physical Activity. Due to the 80% target this indicator remains in the red zone.

To ensure robustness of the data, spot checks were carried out to ensure a minimum of 2 physical activity entries were being completed in a 24 hour period. The spot check showed that there were 2 entries consistently being made per day and the data is therefore robust.

Data recorded is patient participation in Moderate physical activity intervention, this data includes patients participating at the Sports and Fitness, Gardens, ward and hub based activities, escorted walks, Walking Groups. This data also includes patients using Ground Access as a means of physical activity. Caution should be used to this however, as this is based on patient self-reporting.

April – June 2019



No 6 Healthier BMI.

The RiO report shows that 10% of patients have a healthy BMI in June 2019. This is the same figure as March 2019. This compares with 11.6% in December 2018, 14.5% in September and 18.8% in June 2018. This is concerning as there has been a steady decline since June 2018. The data collection has moved to monthly in December 2018 for this indicator with nursing staff taking measurements as opposed to the Dietetic Technician measuring on a 6 monthly basis. This means we have more data being collected more regularly for all patients. This indicator remains in the red zone.

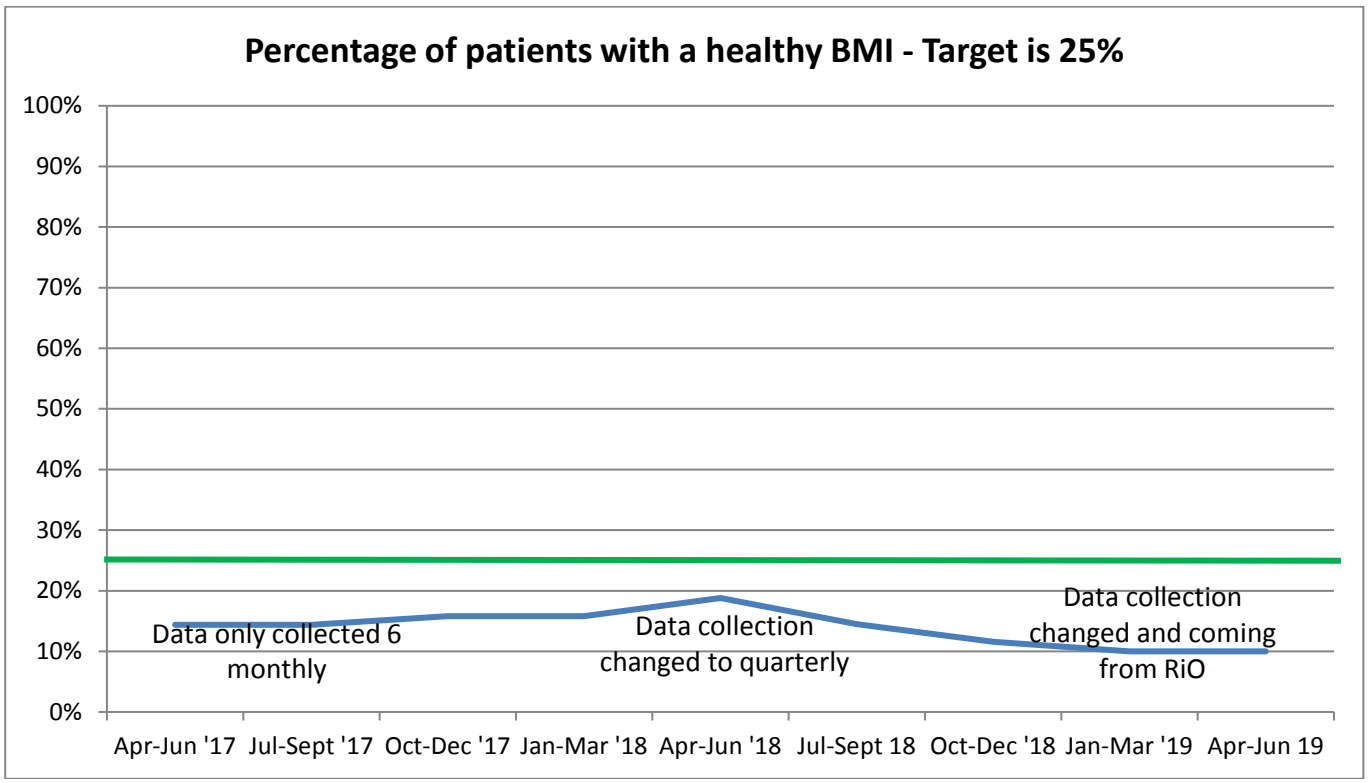


Table 1

Weight Range by BMI	Number of Patients (Q1)	% (Q1)	Number of Patients (Q4)	% (Q4)	Number of patients (Q3)	% (Q3)	Number of patients (Q2)	% (Q2)
<18.5 underweight	0	0	0	0	0	0	1	0.9
18.5-24.9 healthy	11	10	10	10	12	11.6	15	14.5
25-29.9 overweight	38	89	39	90	36	88.4	30	85.5
30-39.9 obese	48		46		48		49	
>40 obese	6		8		7		8	

No 7 Sickness absence.

The sickness absence rate for the quarter was 5.48% with 4.33% long term and 1.15% short term. The monthly figures were 5.55% in April with 4.25% long term and 1.29% short term, 5.34% in May with 4.38% long and 0.96% short and 5.56% in June with 4.36% long and 1.19% short.

This moves this indicator from red to green as the hospital is less than 0.5% away from their target.

No 8 Staff have an approved PDP.

The PDR compliance level at 30 June was 86.3%. This is an increase of 5.4% from the last reporting period (i.e. 31 March 2019).

Although this indicator remains in the red zone, monthly monitoring continues to show a positive upwards trajectory and there is clear evidence of month-on-month improvements in organisational compliance.

Of staff that do not have a completed and approved review, 11.3% have an out-of-date PDR (i.e. the annual review meeting is overdue) and 2.4% have not yet had an appraisal and have no PDP. The latter group are predominantly new staff with an initial set-up review meeting overdue.

No 15 Attendance by clinical staff at case reviews.

Key Worker attendance has decreased slightly to 72% from 74% in Q4. This is still a significant improvement from the Q3 figure of 49%. The target is 80%.

Occupational Therapy attendance has increased from 52% in Q4 to 83% in Q1 against a target of 80%. This indicator moves from the red to green zone.

Pharmacy has decreased from 71% in Q4 to 57% in Q1 against a target of 60%. They remain in the green zone at present.

Clinical Psychologist attendance fell further from the 80% target to 77%, compared to 79% in Q4. They remain in the green zone at present. The Psychology attendance decreased from 98% in Q4 to 91% in Q1. This moves this indicator from the green to amber zone.

Security attendance has increased slightly from 41% in Q4 to 42% in Q1 against a target of 60%. They remain in the red zone.

Social Work attendance decreased from 86% in Q4 to 74% in Q1. This indicator changes to amber as the target is 80%

4 RECOMMENDATION

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

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives?	Monitoring of Key Performance Indicator Performance in the TSH Local Delivery Plan (2017-2020) and the Operational Plan.
Workforce Implications	No workforce implications-for information only.
Financial Implications	No financial implications-for information only.
Route to the Board (Committee) Which groups were involved in contributing to the paper and recommendations?	Leads for KPIs contribute to report.
Risk Assessment (Outline any significant risks and associated mitigation)	There is a dependency on the Business Intelligence project. While we can identify other ways of obtaining and analysing data there will be continue to be limitations on the timeliness and granularity of the information reported.
Assessment of Impact on Stakeholder Experience	The gaps in KPI data which make it difficult to assess.
Equality Impact Assessment	No implications identified.

Appendix 1

Item	Principles	Performance Indicator	Target	RAG Q1	RAG Q4	Actual	Comment	LEAD
1.	8	Patients have their care and treatment plans reviewed at 6 monthly intervals	100%	A	G	92.6%	The figure for March 2019 was 96.1%	LT
2.	8	Patients will be engaged in psychological treatment	85%	G	G	92%	*Figures for June 2019* – 92% (average) engaged in therapy. In June 8 patients were not engaged in therapy. 7 had recently completed treatment and one patient is difficult to engage.	JM
3.	8	Patients will be engaged in off-hub activity centres	90%	A	A	83%	Excludes shop / health centre information (brief visits). This also doesn't include patients who are regularly attending the Café Area	MR
4.	8	Patients will be offered an annual physical health review	90%	G	R	100%	All patients eligible for an annual physical health review were offered for Q1.	LT
5.	8	Patients will undertake 90 minutes of exercise each week	80%	R	R	64.2%	For this quarter the indicator remains in the red zone but has increased from 59.3% in the previous quarter.	MR
6.	8	Patients will have a healthier BMI	25%	R	R	10%	March figure as also 10%. Steady decline since June 2018.	LT
7.	5	Sickness absence rate(National HEAT standard is 4%)	** 5%	R	G	5.48%	5.55% in April, 5.34% in May and 5.56% in June gives a quarterly figure of 5.48%. This is an improvement of 0.86% in the last quarter (6.34%)	KS
8.	5	Staff have an approved PDR	*100%	R	R	86.3%	This indicator has been showing a steady improvement since October 2018.	KS
9.	1, 3	Patients transferred/discharged using CPA	100%	G	G	100%	This indicator maintained at 100% in Q1. All patients had a CPA meeting prior to transfer/discharge. This indicator remains in the green zone.	KB
10.	1, 3	Patients requiring primary care services will have access within 48 hours	*100%	G	G	100%	*Figures for Jan –March 2019*. 97 referrals requiring to meet 48 hour standards. All met.	LT
11.	1, 3	Patients will commence psychological therapies <18 weeks from referral date	**100%	G	G	100%	All patients referred and not already in treatment met the standard	JM
~~12.~~	~~1, 3~~	~~Patients will engage in meaningful activity on a daily basis~~	~~100%~~	-			~~*New indicators and business processes in development as reported to the June Board.*~~	~~MR~~
13.	2, 6, 7, 9	Patients have their clinical risk assessment reviewed annually.	100%	G	G	97.9%	105 patients. 10 new admissions, 93 patients with current risk assessments and 2 risk assessments out of date (one due to section change, the other completed one day late).	LT
~~14.~~	~~2, 6, 7, 9~~	~~Hubs have a monthly community meeting.~~	-	-		-	~~*New indicators and business processes in development as reported to the June Board.*~~	~~MR~~
15.		Refer to next table.						All Clinical Leads

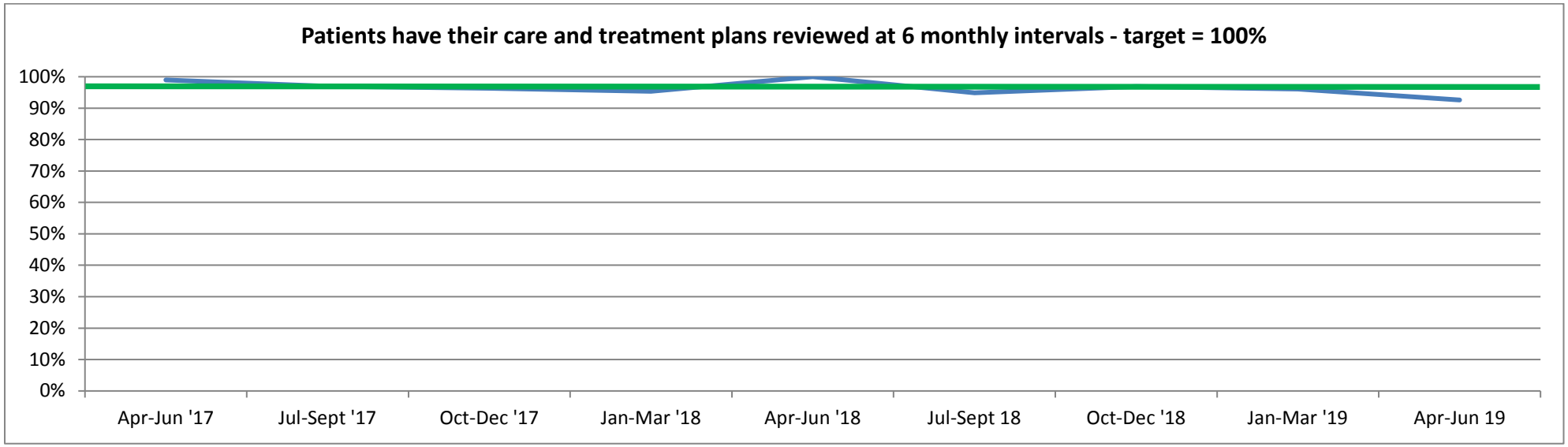
Item	Code	Principles	Performance Indicator	Profession (Lead)	Target	RAG Q1	RAG Q4	Overall attendance April – June 2019(n=50)	Overall attendance Jan-Mar 2019 (n=53)	Overall attendance Oct-Dec (n=51)	Overall attendance July-Sept 2018 (n=44)
15	T	2, 6, 7, 9	Attendance by all clinical staff at case reviews	RMO **(LT)**	90%	G	G	93%	93%	90%	89%
				Medical **(LT)**	100%	G	G	96%	98%	96%	96%
				Key Worker/Assoc Worker **(MR)**	80%	A	A	72%	74%	49%	77%
				Nursing **(MR)**	100%	G	G	100%	98%	96%	96%
				OT**(MR)**	80%	G	R	83%	52%	61%	75%
				Pharmacy **(LT)**	60%	G	G	57%	71%	41%	59%
				Clinical Psychologist **(JM)**	80%	G	G	77%	79%	92%	80%
				Psychology **(JM)**	100%	A	G	91%	98%	98%	89%
				Security**(DW)**	60%	R	R	42%	41%	39%	34%
				Social Work**(KB)**	80%	A	G	74%	86%	71%	80%
				Skye Activity Centre **(MR)** (only attend annual reviews)	tbc	-	-	0%	0%	4%	0%
				Dietetics **(MR)** (only attend annual reviews)	tbc	-	-	67%	59%	30%	0%

Definitions for red, amber and green zone

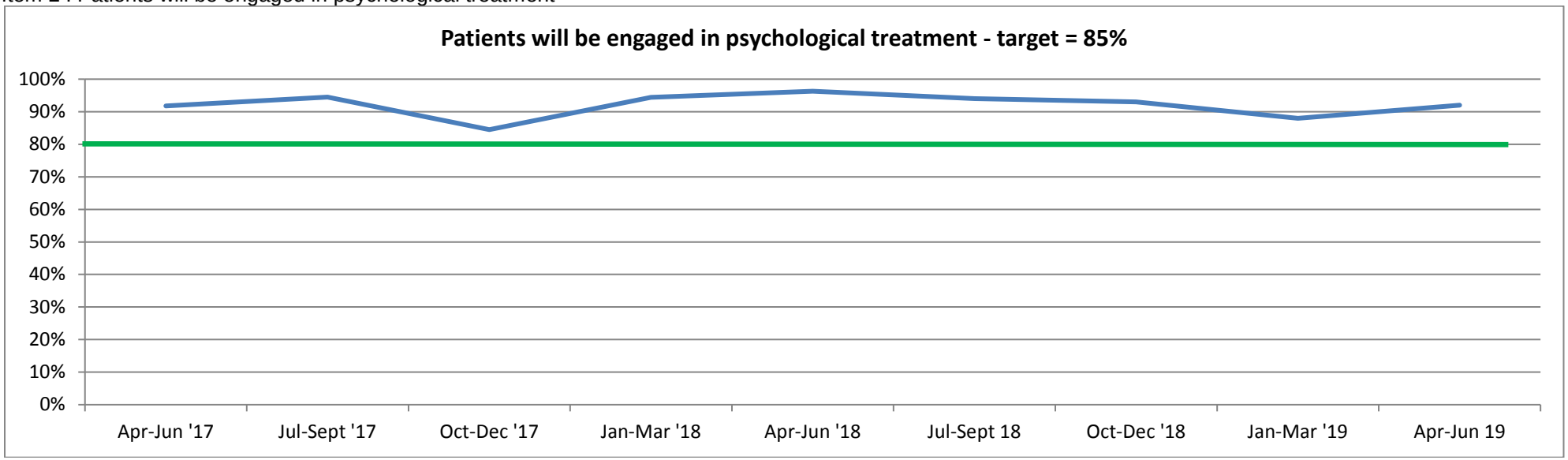
- For all but item 6 and 7 green is 5% or less away from target, amber is between 5.1% and 10% away from target and Red will mean we are over 10% away from target
- For item 6 'Patients have a healthier BMI' green will be 3% or less away from target, amber will be between 3.1% and 5% away from target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

Trend Graphs for Performance Management Data

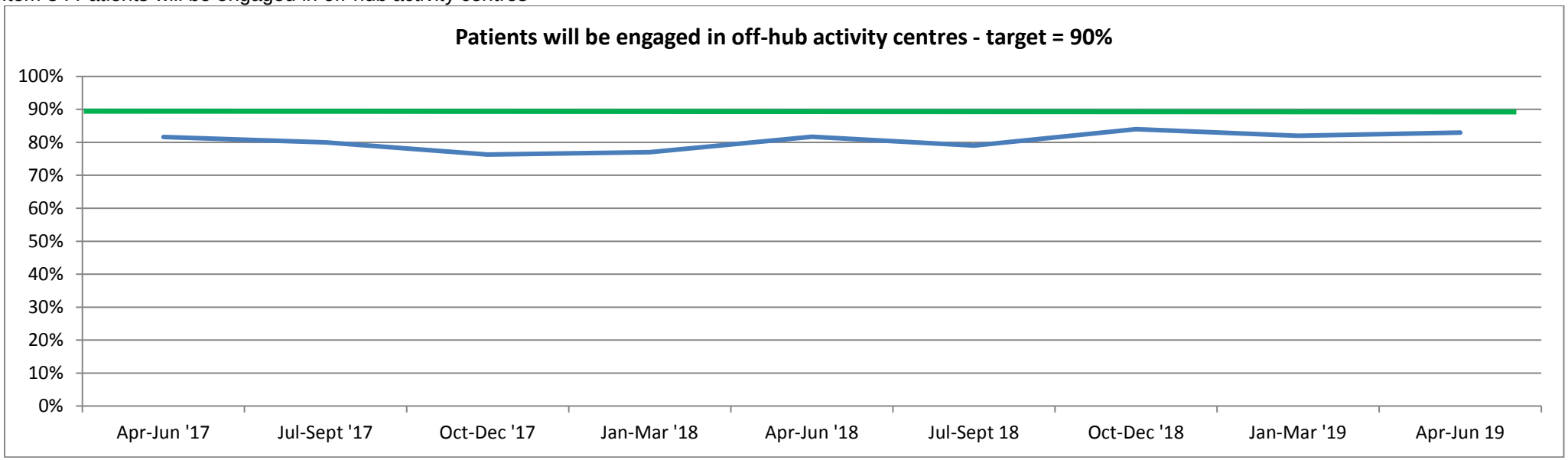
Item 1 : Patients have their care and treatment plans reviewed at 6 monthly intervals



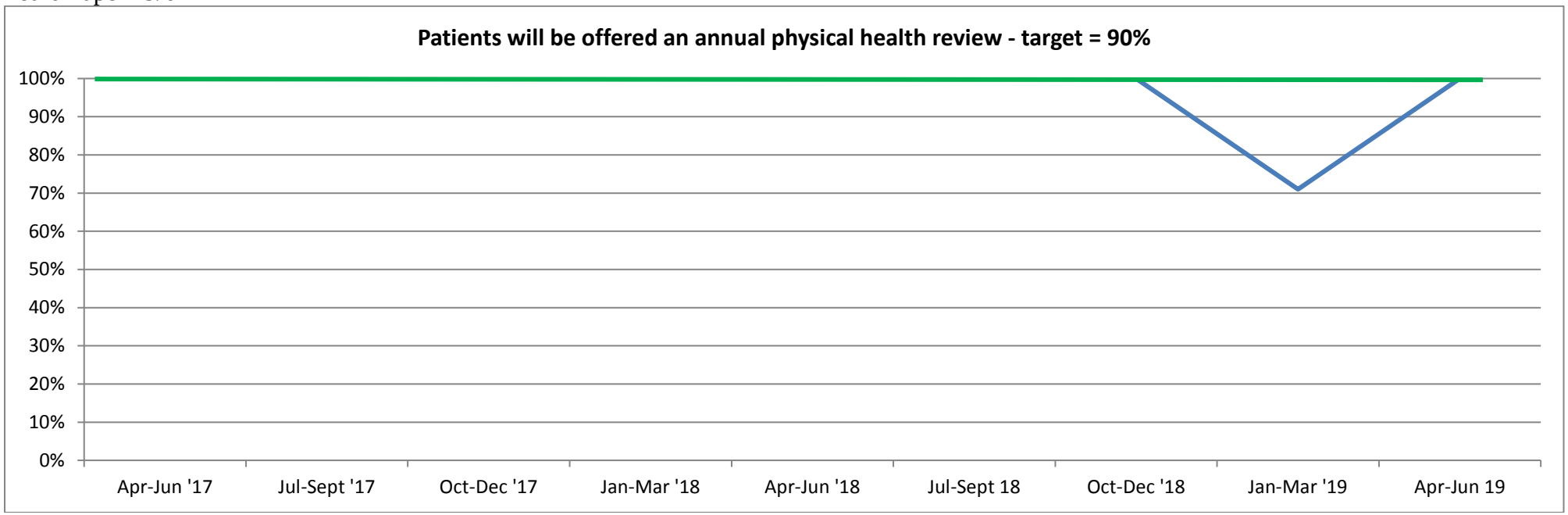
Item 2 : Patients will be engaged in psychological treatment



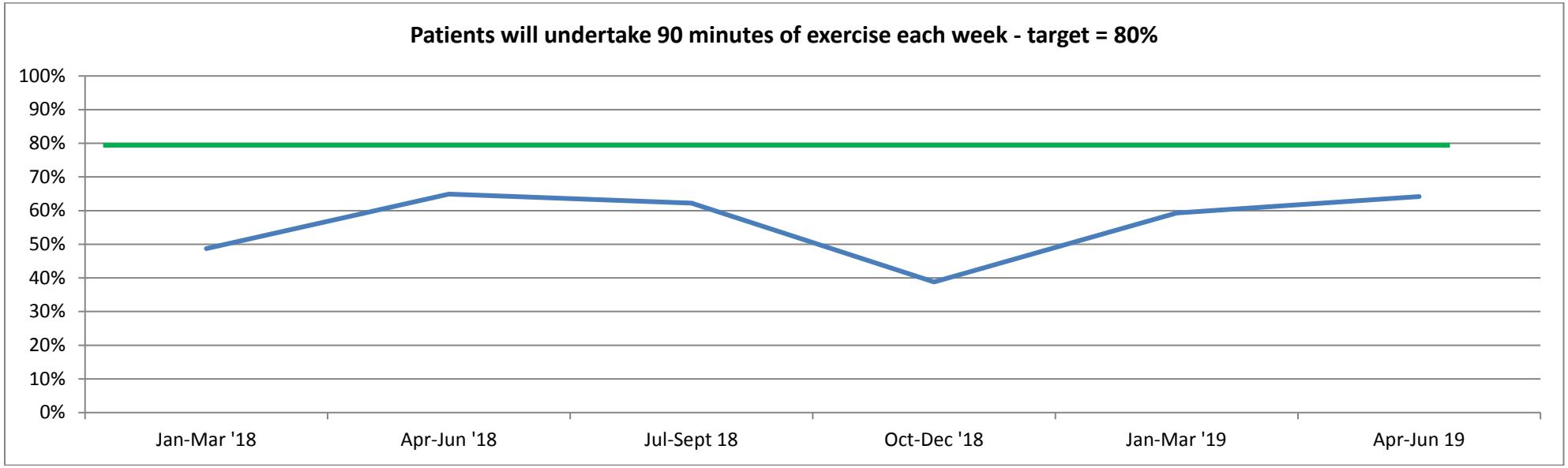
Item 3 : Patients will be engaged in off-hub activity centres



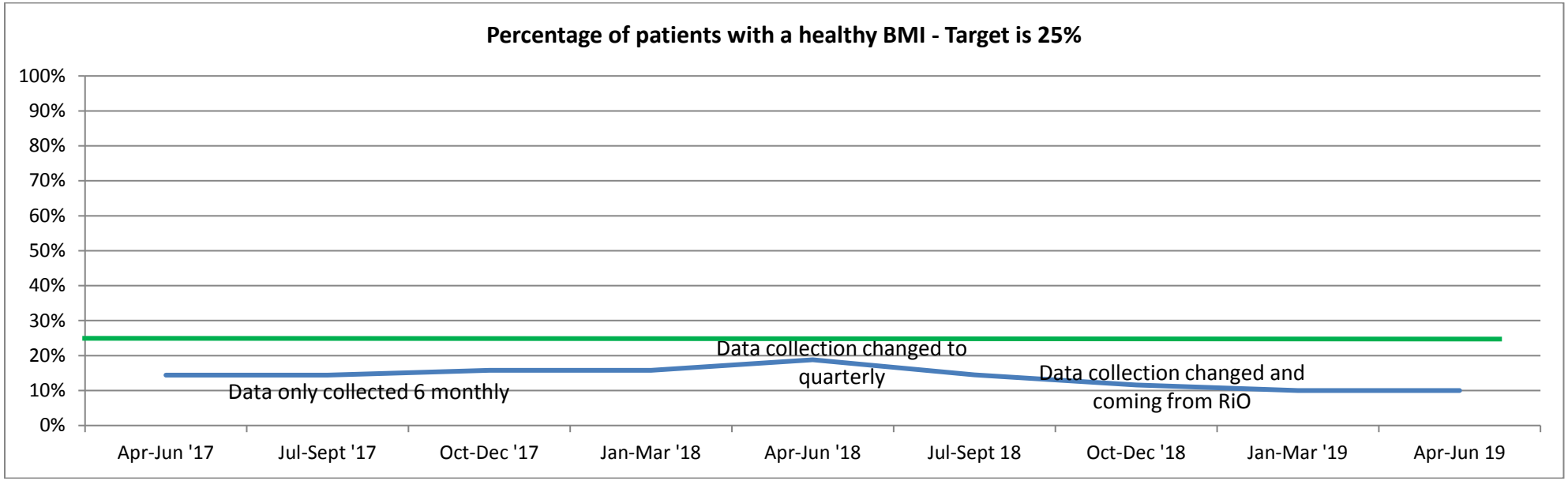
Item 4 : Patients will be offered an annual physical health review



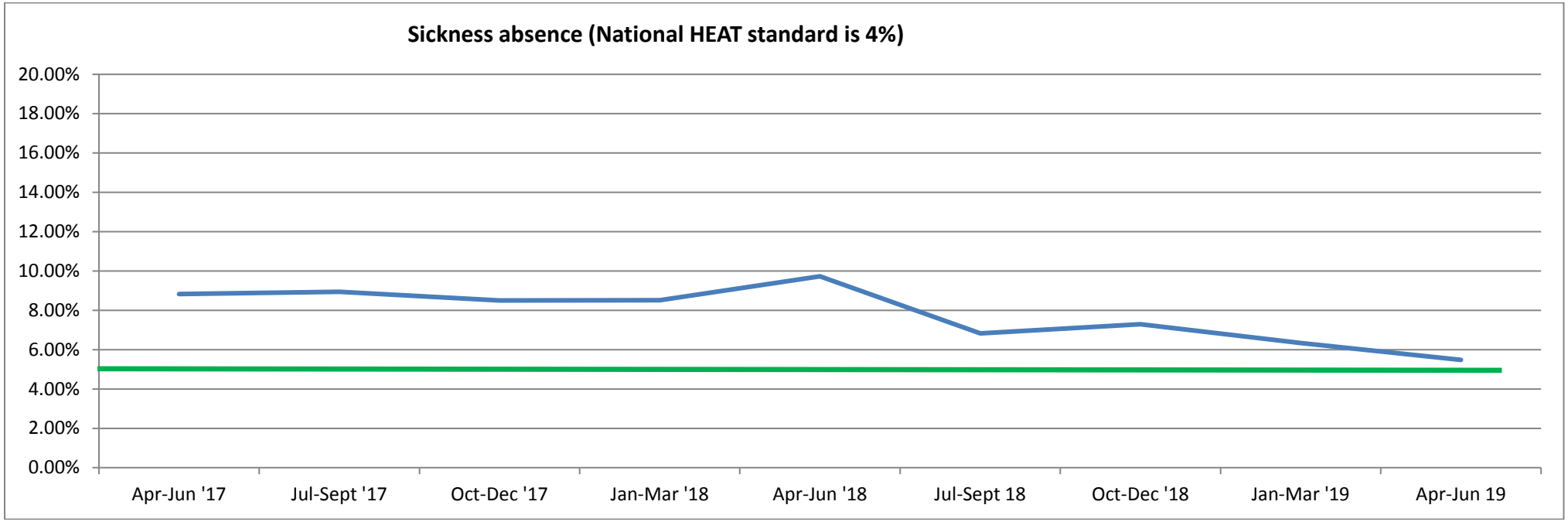
Item 5: Patients will undertake 90 minutes of exercise each week



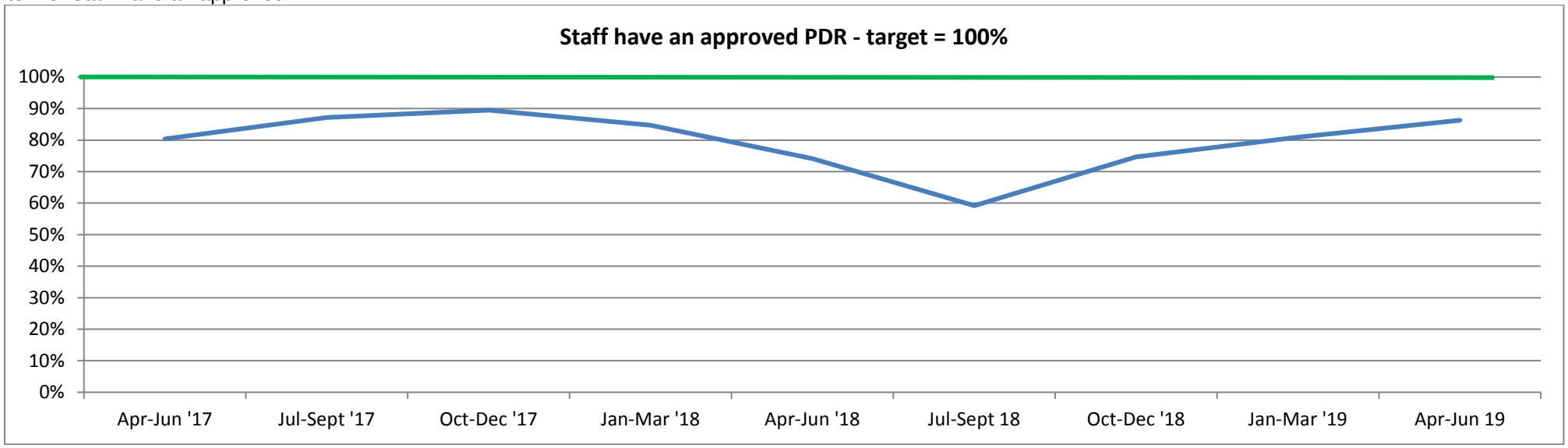
Item 6: Patients will have a healthier BMI



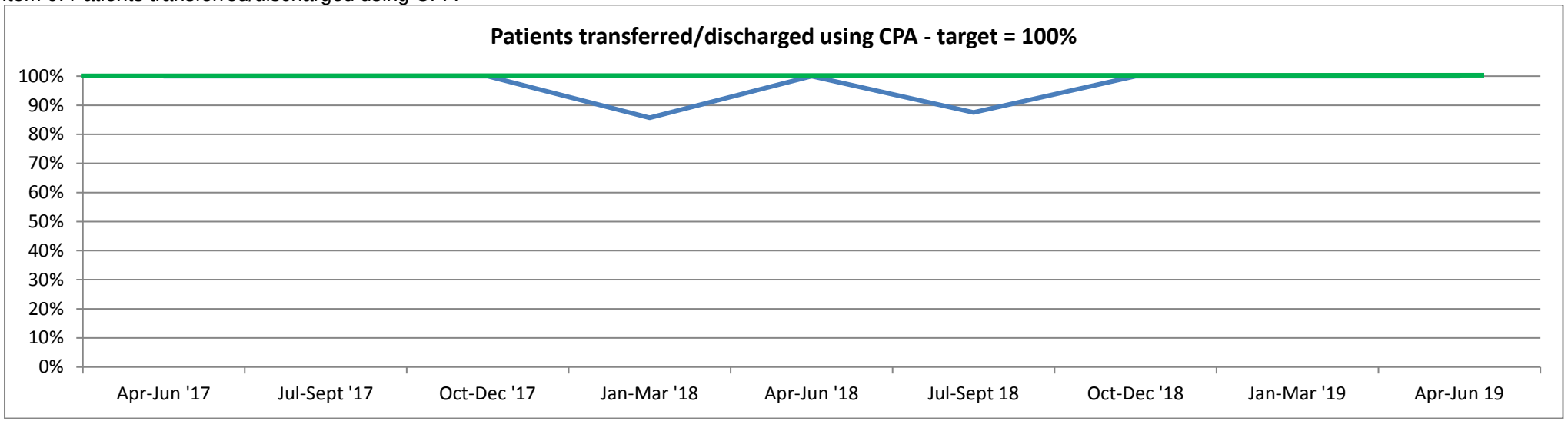
Item 7: Sickness Absence



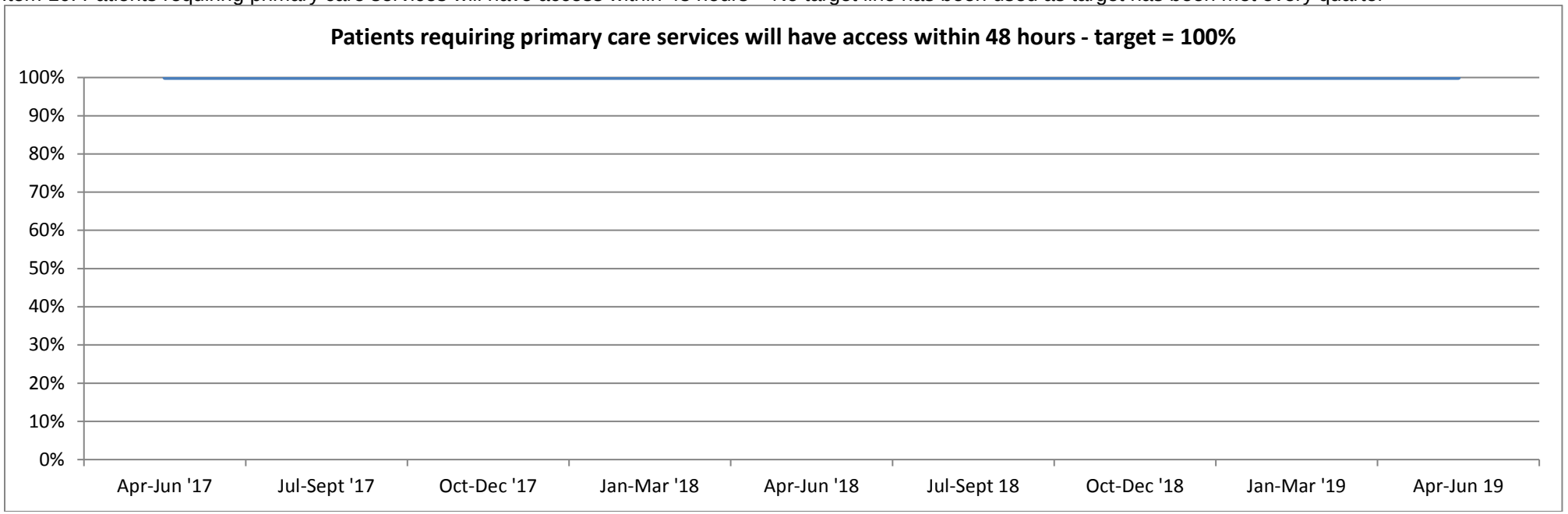
Item 8: Staff have an approved PDR



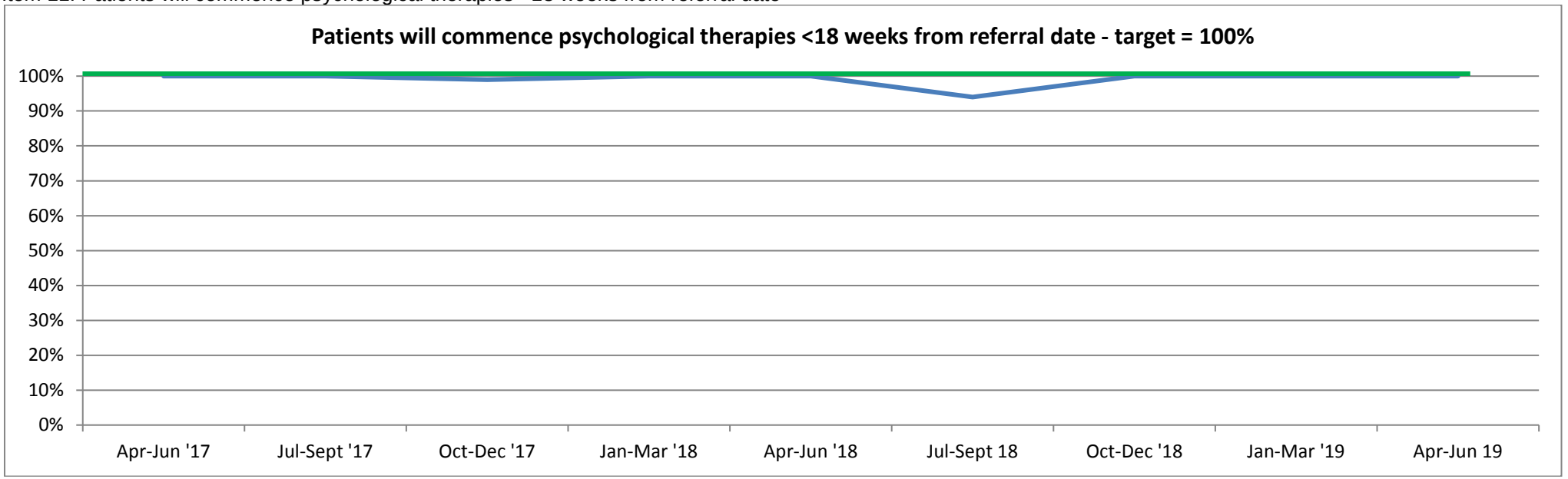
Item 9: Patients transferred/discharged using CPA



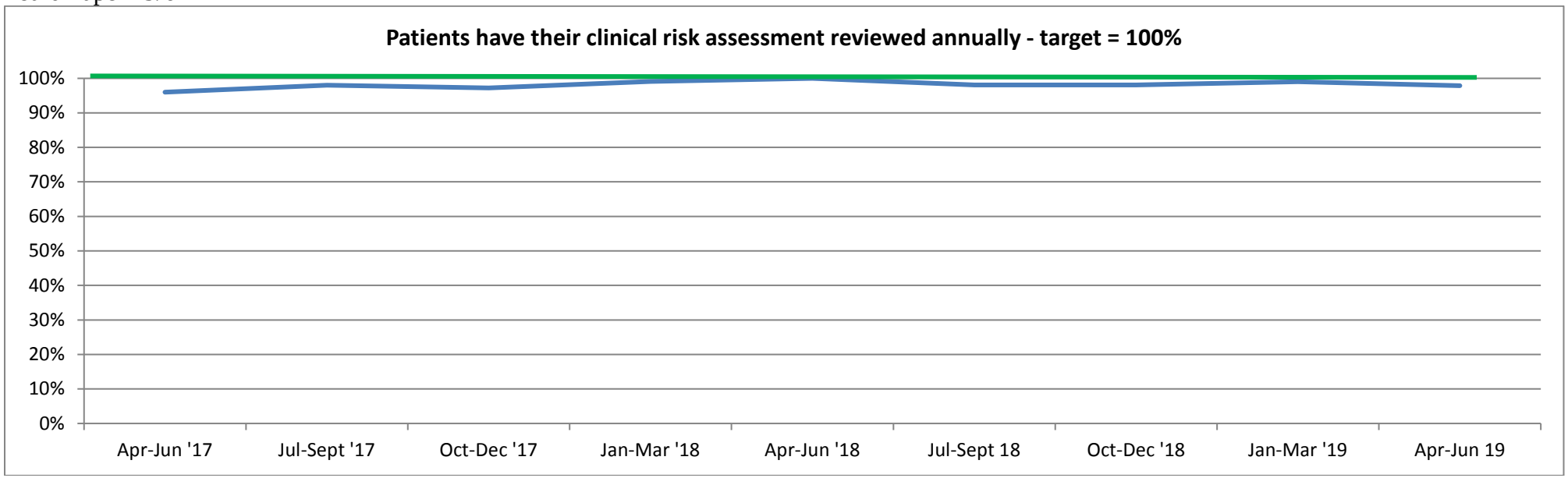
Item 10: Patients requiring primary care services will have access within 48 hours – No target line has been used as target has been met every quarter



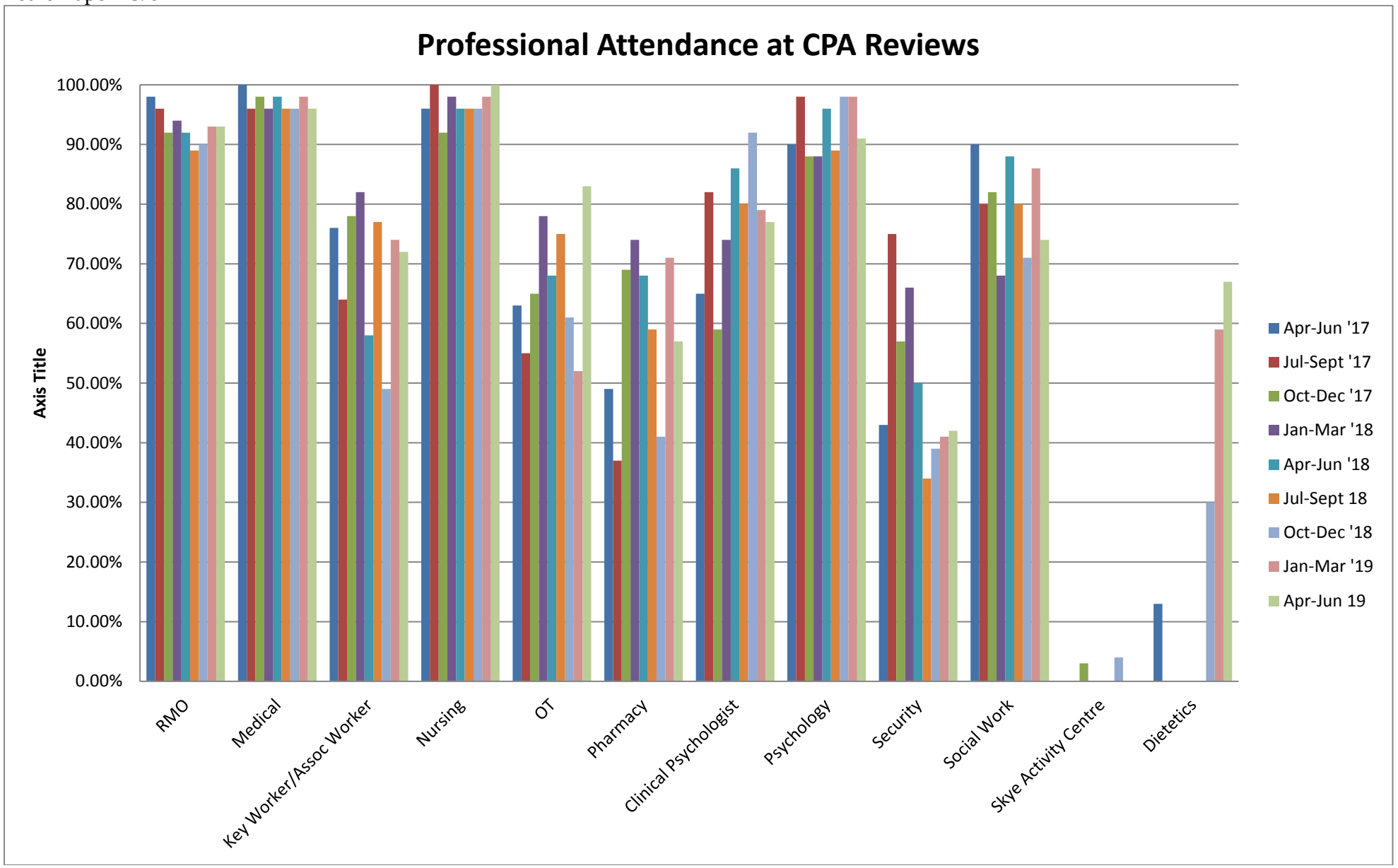
Item 11: Patients will commence psychological therapies <18 weeks from referral date



Item 13: Patients have their clinical risk assessment reviewed annually



Item 15: MDT Attendance at Case Review


Professional Attendance at CPA Reviews
Axis Title
100.00%
90.00%
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
RMO
Medical
Key Worker/Assoc Worker
Nursing
OT
Pharmacy
Clinical Psychologist
Psychology
Security
Social Work
Skye Activity Centre
Dietetics
Apr-Jun '17
Jul-Sept '17
Oct-Dec '17
Jan-Mar '18
Apr-Jun '18
Jul-Sept 18
Oct-Dec '18
Jan-Mar '19
Apr-Jun 19

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 August 2019
Agenda Reference:	Item No: 18
Sponsoring Director:	Finance and Performance Management Director
Author(s):	Head of eHealth
Title of Report:	eHealth Annual Report
Purpose of Report:	For Noting

1 SITUATION

In order for the Board to have an overview of the work carried out by the eHealth Department, an annual report has been created for consideration of the Board members. The eHealth Annual Report aims to highlight the activities of the department during 2018/2019 while also detailing work required for 2019/2020.

2 BACKGROUND

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

3 ASSESSMENT

The report highlights the main areas of activity and concerns form the previous year (2018-2019) The report has no impact on resources or finances for the department.

4 RECOMMENDATION

The Board is asked to **note** the attached report for the year 2018/19 in advance of its publication on the Hospital's internet web site.

MONITORING FORM

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

ANNUAL eHEALTH REPORT

APRIL 2018 - MARCH 2019

Responsible Director	Robin McNaught – Finance and Performance Management Director
Lead Manager	Thomas Best – Head of eHealth
Approved by	
Date Approved	
Date for Review	00/8/19

Contents

1 Overview

2018/2019 has been another challenging year for the eHealth department.

The new Infrastructure team members are now settled and in place with several new team members getting familiar with our working environment. While there are certain projects carried forward for delivery in 2019/20, much has been achieved in the year with prioritisation of the department's focus

Reprioritising projects allowed the Infrastructure and Information teams to deliver most work streams on time but a few unfortunately had to have their delivery dates extended to ensure their successful delivery.

Overall it is recognised that the department has had a successful year with successes such as "Tableau" being rolled out and the Patient Learning Centre hardware refresh now ready for deployment.

Challenges into 2019/20 will be maintaining the momentum of our Records Management Plan, Tableau, upgrading our EPR system RiO, being a pathfinder site for the national eRostering system, the move to Windows 10 and the ground work for identifying what is needed for the organisation's move to Office 365.

2 Information Team

The eHealth Information team will temporarily expand to three members until 2020. The new post will be funded in part by the Excellence in Care Project (EIC) with the funding gap met by eHealth Strategic Funds. This team now provides support for RiO, Tableau and other systems, as well as maintenance and development of our new data warehouse.

The Information Team have also carried out significant work to support nursing resource utilisation and have contributed to national projects including Excellence in Care and the eRostering system procurement.

A major focus has been the delivery of Tableau. Following completion of an extensive requirements gathering process and prioritisation workshop, three task groups have been formed to deliver dashboards for Patient Acuity and Dependency, Physical Health and Activity and Workforce Utilisation. Depending on Information Analyst resources, these dashboards are scheduled for delivery in 2019 and the Project Board will then prioritise the next phase of delivery from the requirements.

Major developments to RiO (Electronic Patient Record) include new modules to support:

- Dynamic Appraisal of Situational Aggression (DASA)
- Health and Well Being Plans
- Clinical Team Meetings (CTMs)
- Psychology Formulations
- Anthropometric Monitoring
- Observation Plans
- Clinical Pause Meetings
- Integration of the Social Work Service
- Patient Timetabling
- New Nursing Care Plans

3 Infrastructure Team

As noted above, the Infrastructure team have been impacted by absence this year. This had held back some projects but plans implemented to resolve this issues were successful. The team have maintained the level of support required and expected by the organisation, while at the same time ensuring that "business as usual" activities are always supported.

Major projects to be delivered in 2019/20 are the deployment of Windows 10, groundwork for our move to Office 365, the RiO Upgrade and the development of out of hours support.

4 Health Records Department

The Health Records Department has had another busy year, with a variety of 'business as usual' tasks as well as proactively undertaking improvements within processes to provide a better service. Requests for patient records (Subject Access Requests, police and other healthcare providers and other miscellaneous bodies) have continued. Records Management has been taken forward with a Records Survey being started and liaison with other departments being a priority for Health Records staff, focussing on patient information in the first instance. Discussions are ongoing with regard to restructuring the department as a Records Services Department. Changes to legislation have meant alterations in processes and some extra pressure on the team, however overall levels of performance and service have remained high.

Work has begun on appraisal of patient records, with some notes now being identified for permanent preservation and others for destruction. Archive material relating to The State Hospital is being catalogued in preparation for removal to archives, or for permanent storage within the department. Department staff continue to attend internal and external meetings and groups, relating to a wide spectrum of topics including Information Governance, Records Management and Healthy Working Lives. Working relationships are being formed and encouraged with external bodies, in particular local and national health boards to maintain knowledge and contribute to future legislation and guidance. There is recognition that the Health Records Department's workload has changed and plans are in place to formalise this. It is noted that the Department is small, and resources are stretched, however improvements continue to be made.

5 Project Management

The demands on our part-time Senior Project Manager also continue to be significant, with a focus on delivering The State Hospital Tableau Business Intelligence system. The Senior Project Manager is also the nominated Evangelist for the National Finance Tableau project with the dashboards for budget holders due to be rolled out from August 2019 onwards.

As The State Hospital is one of three pathfinder sites for the rollout of the national eRostering system, the Senior Project Manager has also been heavily involved in the national procurement process. This system is expected to be rolled out towards the end of 2019 and will require additional project management and eHealth resources.

The planned transition to Version 7 of our Electronic Patient Record RiO will also require project management resources.

6 Key eHealth Projects 2018/19

Storage and backup replacement.

This was the main priority project in 2018/19, and after extensive evaluation the replacement solution was procured in March 2019 and installed in the following weeks, going went live on 20th June without any issues at the time – a matter arose in early July which was addressed promptly and effectively with full supplier support provided.

Going forward, key benefits gained from installing this system are – doubling the amount of storage available (which was strained at its previous capacity), lower power consumption, less cooling requirement and a reduction in licencing costs.

Patients' Learning Centre Infrastructure refresh.

The deployment of new equipment was evaluated and procured in the year, completed on 26th June and the system is now live. Staff and patients will continue to have dedicated IT support for the next few weeks until they are confident everything is operating as required.

Windows 10

We are still working towards deploying Windows 10 to all hospital computers by January 2020. This is the time when Windows 7 goes "out of support" from Microsoft. Through the year, there has been a test group of staff with Windows10 who have helped resolve a number of issues encountered during initial testing.

Preparations are now being made to start the rollout of Windows10 to all new laptop and desktop computers. Testing of our existing laptops and desktop computers has highlighted that some may not be compatible with Windows 10 – and there is a possibility that additional capital funding may be required to purchase more new computers due to this problem. This will be evaluated and addressed through the Hospital's Capital Group.

Office 2016 deployment

Testing of Office 2016 has been completed in 2018/19 with several staff already using this - so no additional testing is expected to be required. Funding for the purchase of Office 2016 has to be reviewed although eHealth Strategic Funds may be a suitable funding source. The eHealth Strategic Fund is used to implement eHealth strategy. It is a funding stream from Scottish Government which is a ring-fenced resource to support a range of eHealth priorities such as upgrading software to meet the Network Information Systems Directive compliance. Once the licences have been purchased Office 2016 will be gradually rolled out to all hospital computers – these licences are only intended for temporary use until all boards move to Office 365 in the few years. (They are supplied via NSS at a reduced price that was agreed as part of the Office 365 Project.) This will allow us to completely remove the unsupported Office 2007 package and ensure our Microsoft Office software is compliant with the forthcoming NIS Directive and the requirements for Cyber Essentials accreditation.

RiO EPR upgrade to version 7

This has been under review through the year, and while upgrade was initially planned to begin in April 2019 but has been held back due to delays by the supplier. A kick off meeting has still to be held and a revised start schedule will be delivered from this.

Tableau business intelligence tool

Extensive work has been undertaken in the year to develop Tableau and the Information Team are keen to harness the power of Tableau and use their BI skills to deliver information at the point

of decision making. The team are working with short term tasks groups and taking an agile, prototyping approach to the development of the dashboards prioritised for the first phase of the rollout, and will work with the Project Board to agree the scope and priority areas for the next phase of the project delivery.

7 eHealth Cyber Security

Cyber Essentials

We have had two Cyber Essentials assessments in the last twelve months. We unfortunately did not achieve full compliance due to older unsupported software still in use at the hospital. There is now a focus to improve this position but the 2019/20 replacement of the Security Visitor System and the upgrade to Office 365 from 2007 will require completion before re-assessment.

Although these two application had an impact on our Cyber assessment our network access was found to be secure and could not be breached internally. Our Internet connection was also secure and is protected by devices on site and nationally on the SWAN network. Our staff have the minimum computer access rights needed to undertake their roles and this can prevent computer viruses form installing and preventing them for taking hold.

The changes made to the IT Infrastructure over the last few years has strengthened our protection against cyber-attack. However we need to keep vigilant as technology develops and new threats to our Infrastructure are developed.

Software Patching

Software patching is seen as the most effective way to ensure the security of our digital estate. This process was previously undertaken “ad hoc” with patches being rolled out when possible. However there has been a key development in 2018/19 with the deployment of a product called Ivanti Heat to assist with managing this process. This application was provided as part of a national initiative funded by the Scottish Government’s eHealth Department. The software monitors the patching level of all hospital computers and helps to manage the deployment of both Microsoft and non-Microsoft computer patches. The output for this system is also available to the Security Team at NSS to help with monitoring our patch level and the patch level of other board who are part of this project.

8 Priority eHealth Projects for 2019/20

Continuation of Windows10 roll-out

Office 2016 deployment

Rio EPR upgrade to version 7

Introduction of patient timetables

eRostering pilot (National – TSH is a Pathfinder Board)

Continuation of Tableau roll-out (TSH)

Finance Tableau Dashboard roll-out (National)

Excellence in Care (National)

Visitor booking system replacement

Remote site connectivity

9 eHealth Collaborative Working

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

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

Board Paper 19/63

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 August 2019
Agenda Reference:	Item No: 19
Sponsoring Director:	Finance and Performance Management Director
Author(s):	Senior IM & T Analyst & ITSO
Title of Report:	Network Information Systems Regulation (NIS) and the Information Security Policy Framework (ISPF) 2018
Purpose of Report:	To raise awareness and provide an understanding of the requirements to be compliant with the regulation

1 SITUATION

The recent introduction of the Network and Information Systems Regulation 2018 (NIS 2018) has placed a legal requirement on organisations within the United Kingdom that are considered part of the critical infrastructure. Over the past year there has been frequent discussions about NIS and the Information Security Policy Framework 2018 (ISPF 2018) in National Information Security meetings. As yearly audits will be carried out to ensure compliance, there is a real concern that not much, if any, consideration has been given to the NIS Regulation and the ISPF 2018 by the organisation. As there are big financial fines, up to £17 million, for organisations that are not compliant, action needs to be taken to ensure we avoid those fines.

2 BACKGROUND

The NIS Regulation, based on the EU's NIS Directive, was passed around the same time as the General Data Protection Regulation (GDPR) 2018, was brought in to apply security standards to the United Kingdom's critical infrastructure and services. As everyone is affected by GDPR there was a lot of media attention and plenty of information available when it was due to be implemented. Unfortunately, NIS has not received the same attention due to the regulation only being imposed on organisations that provide critical services, such as energy, transport, health, digital infrastructure and water supply.

3 ASSESSMENT

More awareness has needed to be raised in regards of the NIS Regulation and the ISPF 2018. Endorsement by the SMT and from the Board will assist in highlighting the importance of being compliant with the NIS Regulation using the ISPF 2018, as there will be a requirement for other directorates, within the organisation, to have some direct involvement.

The SMT has noted the need for a board-level individual, currently assigned to the Finance and Performance Management Director, who has overall accountability for the security of networks and information systems, the requirement for a new post/role to be created or changes to a current post/role with the responsibility of overseeing and advising on information security concerns, the

need for other directorates to have direct involvement in evidence gathering for compliance audits and noted there may be a requirement for funding for security systems, tools and training.

4 RECOMMENDATION

The Board is invited to: (note / endorse / agree to) the following recommendations:

- Note progress in this matter has been raised to the SMT, who in turn noted the actions required and have requested further updates in due course.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	To ensure compliance with regulation. Legal obligation.
Workforce Implications	Directorates and personnel need to be identified to carry out gap analysis and provide evidence. Possible new role to be created/adjusted and/or group setup to check/ensure compliance with regulation (suggested at IT SUB Group).
Financial Implications	Fines can be imposed if the organisation is not compliant with the regulation. Systems/Tools may be required to comply with the regulation.
Route To SMT Which groups were involved in contributing to the paper and recommendations.	IT SUB Group
Risk Assessment (Outline any significant risks and associated mitigation)	Financial, reputational, information security, non-compliance with other regulations (GDPR), non-compliance with NIS regulation.
Assessment of Impact on Stakeholder Experience	
Equality Impact Assessment	There should not be any impact on equality, or none that has been identified yet.
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	N/A
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One √ There are no privacy implications. □ There are privacy implications, but full DPIA not needed □ There are privacy implications , full DPIA included.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 August 2019
Agenda Reference:	Item No: 20
Sponsoring Director:	Chief Executive
Author(s):	Head of Communications Person Centred Improvement Lead
Title of Report:	Communications Annual Report 2018/19
Purpose of Report:	For Noting

1 SITUATION

The Head of Communications is required to produce a Communications Annual Report. This report covers performance from 1 April 2018 to 31 March 2019.

2 BACKGROUND

All communications activity supports the Board in the delivery of its core objectives and legal obligations. The establishment of a Communications Annual Report is therefore an important assurance process in considering the effectiveness of State Hospital internal and external communications.

Given the nature and organisational arrangements of the Board, patients are uniquely viewed as internal communication stakeholders in addition to Non-Executive Directors, Volunteers, the Chaplaincy Team, Advocacy and staff. Carers, the public and the media are included within external communication arrangements.

The two services predominately delivering internal and external communications are the Communications Service and the Person Centred Improvement Service (PCIS).

3 ASSESSMENT

Overall, core Communications tasks were delivered, all legislative requirements were met, and all financial targets / savings were achieved.

A breakdown of the 78 key areas of activity is shown below:

- There were 26 tasks relating to core objectives (compared to 22 in 2017/18). Of these 13 were Key Performance Indicators (KPIs) (as per 2017/18), and the remaining 13 (nine in 2017/18) on outputs in respect media, public, patient, carer, volunteer, external, and staff activity.

- Additionally, 52 objectives focused on quality (compared to 36 in 2017/18); 19 relating to quality assurance (same as 2017/18) and 33 to quality improvement (24 in 2017/18). The latter evidencing our commitment to continuous improvement.

However more needs to be done to address negative media reporting and to raise the profile of The State Hospital (both within and outwith NHSScotland) with all stakeholders including regulators, partner organisations, the public, the media etc. Disappointingly, as in previous years, some negative coverage has been initiated via leaks by staff to the media. Attempts to source these individuals have been unsuccessful. These media issues should in no way detract from the good work that has taken place across all strands of communications, both internal and external, attracting positive attention.

4 RECOMMENDATION

The Board is asked to note the Communications Annual Report 2018/19.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	All communications activity supports the Hospital to meet its strategic objectives as outlined in the Hospital's Local Delivery Plan / Annual Operating Plan.
Workforce Implications	Resilience challenge identified.
Financial Implications	N/A
Route To Board Which groups were involved in contributing to the paper and recommendations.	Person Centred Improvement Service (PCIS)
Risk Assessment (Outline any significant risks and associated mitigation)	N/A
Assessment of Impact on Stakeholder Experience	No direct impact other than protecting the Hospital's reputation and patient / staff confidentiality as well as ability to keep all stakeholders properly informed.
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).	The Head of Communications works closely with the Person Centred Improvement Lead to support an inclusive approach to ensuring patients who experience significant barriers to communication are enabled to contribute meaningfully to all aspects of care and treatment.
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.

COMMUNICATIONS ANNUAL REPORT 2018/19

THE STATE HOSPITALS BOARD FOR SCOTLAND

1. CORE PURPOSE

Effective communications plays a key role in how all stakeholders perceive The State Hospital.

The core purpose relates to all aspects of communications both internally and externally - from consultancy / advice and guidance to the provision of electronic communications and the production of corporate publications. In particular, the The Head of Communications acts as communications link between the Hospital and stakeholders including staff, the local community, general public, professional bodies, and local and national government, and drives forward improvements in communication. This enables the influencing and shaping of communication planning and strategy at all levels, ensuring good communications practice is firmly embedded in everyday service development, delivery and change.

Given the nature and organisational arrangements of the Board, patients are uniquely viewed as internal communication stakeholders in addition to Non-Executive Directors, Volunteers, the Chaplaincy Team, Advocacy and staff. Carers, the public and the media are included within external communication arrangements. This is where communications differ from that of other Boards. The State Hospital's general public (patients) are long stay therefore our internal stakeholders. The general public as a whole are potential patients of territorial Boards and are viewed by them as external stakeholders. These Boards will therefore undertake direct engagement with their general public in relation to health, wellbeing and services provided.

Key results areas include:

- Stakeholder Communications (internal and external).
- Public Relations.
- Media Relations.
- Crisis Communication.

2. CORE OBJECTIVES

All communications activity supports the Hospital in the delivery of its core objectives. In particular those relating to:

- National Staff Governance Standard (4th edition), June 2012.
- NHSScotland Healthcare Quality Strategy, May 2010.
- NHSScotland 2020 Workforce Vision (*Everyone Matters*), June 2013.
- Scottish Health Council – Participation Standards, August 2010.
- Healthcare Improvement Scotland (HIS) – What Matters To You? August 2016.

3. STRATEGY AND POLICY

Communications is delivered in line with our Corporate Communications Strategy which meets the legal obligations contained within:

- Human Rights Act 1998.
- Public Interest Disclosure Act 1999.
- Freedom of Information (Scotland) Act 2002.
- Equality Act 2010.
- Public Services Reform (Scotland) Act 2010.
- Patient Rights (Scotland) Act 2011.
- Mental Health (Care and Treatment) (Scotland) Act 2003 / 2015.
- Carers (Scotland) Act 2016.
- Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016.
- General Data Protection Regulations (GDPR) 2018.
- Duty of Candour Procedure (Scotland) Regulations 2018.
- Fairer Scotland Duty 2018.

The Board's Corporate Communications Strategy 2015/20 – which is available on The State Hospital's Website under Board Business - focuses on internal and external corporate communications. It supports the aspirations of the Board and is regularly reviewed in a collaborative manner in line with effective partnership working practices, and best practice in involvement, engagement and consultation processes.

The Media Policy & Procedure, Website Maintenance & Development Policy and other relevant documentation support the Corporate Communications Strategy including the discrete Pandemic Influenza Communications Strategy 2015/20.

Additionally:

- The Supporting Patient Communication Policy is currently being developed in collaboration with stakeholders in response to legislation, national drivers and local feedback. The policy will support an individually tailored approach to meaningfully engaging all patients throughout their time in the Hospital.

- In response to feedback from internal and external stakeholders, the Person Centred Improvement Service Delivery Plan was developed in 2018/19 replacing the Involvement and Equality Strategy. This title more appropriately describes the wider function of the service, making explicit the contribution of its diverse workstreams to strategic objectives.

4. KEY PERFORMANCE INDICATORS (KPIs)

Established KPIs relate to the core Communications function as detailed below:

No	KPI	Source	Timescale	Status / Outcome
01	To produce a Communications Annual Report for presenting to the Board.	Board	By August each year	Continues to be met
02	To produce the Board's Annual Report.	Board	By 31 October each year	Continues to be met
03	To produce at least 44 weekly bulletins for staff.	CEO	By end March 2019	Complete A total of 52 were produced.
04	To produce at least 40 special bulletins as a support to staff.	CEO	-	Complete At the request of staff, 66 were produced.
05	To produce Staff Newsletter 'Vision' twice a year as a minimum.	CEO	By end March 2019	Complete Four issues were produced.
06	To deliver on 100% of all appropriate requests for Talks to the Community.	General Public	By end March 2019	Complete Three general State Hospital presentations were delivered.
07	To respond to 100% of urgent Media Enquiries within the timescale requested and within one working day.	Media	By end March 2019	Complete There were 40 media enquiries.
08	Meet the requirements of the 'Well Informed' Staff Governance Standard.	Staff Governance Standard	March / April 2019	Complete Achieved and evidenced by way of the 'Well Informed' section of The State Hospital's Staff Governance Standard Monitoring Return 2018/19.
09	To ensure attendance at four of the six State Hospital Board Meetings.	Board	Annually	Continues to be met Criteria met.
10	Ensure Board business is published on the Website. This includes: Board Meeting Dates, Public Notices, Agendas, Minutes & Papers.	Board	Ongoing	Continues to be met Additionally, after each Board Meeting a review all Board papers takes place with a view to identifying information / communication for the staff bulletin, staff newsletter 'Vision', Intranet, Website and the Media as appropriate.

No	KPI	Source	Timescale	Status / Outcome
11	To attend 90% of NHSScotland Strategic Communications Network Meetings.	NHSScotland	By end March 2019	Complete Criteria met.
12	To ensure representation at the annual NHSScotland Event.	NHSScotland	Annually in June	Continues to be met The Board agreed that no 'stand' would be taken at the June 2018 event.
13	Annual re-design of Weekly Staff Bulletin and Special Bulletin.	Chairperson	By end March annually	Continues to be met

The table below details activity not covered by KPIs:

No	Workstream	Lead	Outcome	Key Result Area
01	Media Releases	Head of Comms	Two Media Releases were issued to the local press: (1) Annual Review – 24/12/18 and (2) New CEO – 16/01/19.	Media Relations
02	Media Features	Head of Comms	There were none.	Media Relations
03	Media Leaks	Head of Comms	Seven were reported through Datix.	Media Relations
04	FOI Enquiries	FOI Lead	Thirty three enquiries were responded to.	Public Relations
05	Academic Published Articles	Research & Development Manager	The Research Committee and Research Funding Committee Annual Report 2018/19 notes 19 published journal articles and the delivery of 45 presentations.	Public Relations
06	Continue to invite visitors to the Hospital to learn about our work. Visitors include MSPs, Health Board Chairs and senior officials as well as other stakeholders.	Executive Team	Ongoing annually as outlined in the Chief Executive's Report to each Board Meeting.	Public Relations
07	Patient Newsletters	Person Centred Improvement Advisor (PCIA)	A weekly patient bulletin is produced which is displayed on all patient noticeboards within the Hospital.	Patient Relations
08	Carer Updates	PCIA	In response to GDPR requirements from 2018, Carer Newsletters were replaced by specific, targeted Carer Updates, e.g. service delivery, safety and security, infection control.	Carer Relations

No	Workstream	Lead	Outcome	Key Result Area
09	Carer Events	PCIA	From 2018, in line with GDPR, information about social events is shared with carers who have consented to receiving such communication.	Carer Relations
10	Volunteer Updates	PCIA	To meet GDPR regulations, the Staff Bulletin and other relevant information is shared with volunteers who have consented to receive same.	Volunteer Relations
11	Networking: Presentations / Workshops	Person Centred Improvement Lead (PCIL)	To share best practice, address stigma and respond to national drivers on a range of topics including Spiritual & Pastoral Care, What Matters To You?, Volunteering including development of Impact Assessment Tool & Volunteer Visitor Programme, Person Centred Quality Improvement initiatives including flexible visiting and engaging hard to reach patients, Equality agenda including Protected Characteristics and Equality Impact Assessments.	External Networking
12	Stakeholder Stories	PCIL	Present feedback from patients, carers and volunteers regularly directly to the Board.	Board Awareness
13	Leadership Walkrounds	Executive Team	Seven took place.	Staff Relations

5. QUALITY ASSURANCE (QA) OBJECTIVES

The table below shows all QA Objectives for 2018/19 and progress against same:

No	QA Objective	Source	Lead	Timescale	Status / New Timescale
Internal Communications					
01	Review all patient publications in line with 'Accessible Information' standards.	Patient Feedback	PCIL and Head of Comms	March 2020	Work commenced in 2018. Around 75% complete
02	Annual review and update of all Person Centred Improvement Service text on The State Hospital Intranet.	Person Centred Improvement Steering Group (PCISG)	PCIL	Annually	Continues to be met

No	QA Objective	Source	Lead	Timescale	Status / New Timescale
			Internal Communications		
03	Review the operating effectiveness of the Intranet for staff with a focus on content and the current document management system (i.e. Sharepoint).	Executive Team	Head of eHealth	March 2020	Outstanding Task timeframe was originally March 2018. Review has still to take place to agree the effectiveness and future direction of the Intranet. Review likely to commence early 2020. Currently Sharepoint is out of support with Microsoft and requires upgrading. Following the review, a paper will go to the IT sub group for discussion and recommendation, prior to options being presented to SMT re the way forward. Timescale adjusted accordingly.
04	Review and update publications (as appropriate) in the Hospital's Publications Database.	Comms	Head of Comms	Ongoing	**Completed 2018/19** New, reviewed and / or updated information sheets included: AHP Student information (AHP), Board Biographies (Corporate), State Hospital 'About Us' (Corporate), Health Centre timetable (Health Centre), Access to Patient Records (Health Records), EASY Sickness Absence (HR), Freedom of Information (FOI) (Information Governance), Stressful Incident (OHS), Time for Talking (OHS), Safety and Security Requirements (Security), Siren (Security), and Therapies and Activities (Skye Centre), Suicide booklet (Nursing Practice Development). **New for 2019/20** A review of all information sheets for Dietetics, the Health Centre, Infection Control, Physical Health Steering Group, Psychological Therapies Service, and Social Work.

No	QA Objective	Source	Lead	Timescale	Status / New Timescale
			Internal Communications		
05	Review of the Staff Charter.	Comms Audit	Interim Director of HR	March 2020	**New for 2019/20**
			External Communications		
06	Annual review and update of all Person Centred Improvement Service publications.	PCISG	PCIL	Annually	Continues to be met
07	Undertake an annual review and update of the content on the Website.	Comms	Head of Comms	By August each year	Continues to be met
08	Annual review and update of all Person Centred Improvement Service text on The State Hospital Website.	PCISG	PCIL	Annually	Continues to be met
09	Production of Employment Monitoring Reports for the Website.	Equality Act	Interim Human Resources Director	Every two years – June 2021	Ongoing Report for 2018/19 published on web 06/06/19.
10	Produce an annual report on Website statistics for 2018/19.	Comms	Head of Comms	March 2019	Complete
11	Explore Web Archiving with National Records Scotland (NRS).	Records Management Plan	Health Records	December 2019	On target Initial meeting May 2018, Web Archive Questionnaire issued June 2018. Archiving to commence around June 2019.
12	Undertake an annual review and update of the content on the ONELAN screens.	Comms	Head of Comms	By August each year	Continues to be met
13	Undertake annual reviews and updates of the State Hospital's Speakers' Directory and general presentation slides.	Comms	Head of Comms	March 2019	Complete This is done based on feedback from presentations.
14	Ensure Contingency Planning Comms contacts (Police, Fire and Ambulance) are updated.	Security Director	Head of Comms	Annually	Ongoing Next update due June 2019.

No	QA Objective	Source	Lead	Timescale	Status / New Timescale
			External Communications		
15	Review of Contingency Planning Comms Statements.	Comms	Chief Executive / Head of Comms	March 2020	On target Regular review takes place as per good practice.
16	Bi-annual review of Media Training requirements for Directors and other identified staff.	Comms	Chief Executive / Head of Comms	March 2020	On target
17	Familiarisation with **'**Dealing With The Media' Guidance for State Hospital Spokespeople	Head of Comms	On-Call Directors / CEO	December 2019	**New for 2019/20** This should be read in conjunction with the: • 'Drop the Pink Elephant' (15 ways to say what you mean…and mean what you say) book given to Directors following media training. • The State Hospital's approved 'Media Lines for On-Call Directors' which have been prepared to assist Directors in responding to media enquiries.
			Strategy / Policy		
18	Carry out an interim review and update (if required) of Communications strategies, policies and procedures.	Comms	Head of Comms	By December 2018	Complete
19	Undertake Equality Impact Assessments for Communications.	Equality Act	Head of Comms	March 2019	Complete

6. QUALITY IMPROVEMENT (QI) OBJECTIVES

The following table details QI Objectives for 2018/19 including progress against same:

No	QI Objective	Source	Lead	Timescale	Status / New Timescale
		Internal Communications			
01	Undertake Annual Patient Experience Questionnaire.	PCISG	PCIL	Ongoing	Complete As a result of patient feedback, a decision was made 2018/19, supported by SMT, to cease facilitation of this questionnaire. **New for 2018/19** Feedback will continue to be sought through a range of methods including What Matters To You?, social events and targeted questionnaires.
02	Develop a Workbook to promote patient physical activity and wellbeing.	Supporting Healthy Choices Steering Group	Physical Health Steering Group (PHSG), Patient Partnership Group (PPG), PCIL and Head of Comms	March 2019	Complete Workbook produced March 2019.
03	Review the existing Patient communication resources.	What Matters To You (WMTY) initiative - June 2017	PCIL / PPG	March 2019	Complete Patient Welcome Pack produced January 2019.
04	Review the existing Volunteer communication resources.	WMTY	PCIL / Volunteer Service Group (VSG)	March 2019	Complete Volunteer Welcome Pack and Induction Workbook produced February 2019.
05	Develop a Volunteer Exit Feedback Form.	WMTY	PCIL / VSG	March 2019	Complete
06	Continue to undertake Staff Engagement Exercises to support corporate objectives.	Directors Objectives	Head of Comms	Ongoing	Continues to be met Clinical Model Principles in October 2018.

No	QI Objective	Source	Lead	Timescale	Status / New Timescale
Internal Communications					
07	Ensure effective communication with relevant stakeholders to share updates relating to strategic priorities including the Clinical Model, Sickness Absence, and Nursing Resource Utilisation.	Chief Executive / Service Strategy / Directors' Objectives	All Directors	March 2019	Complete
08	Promote the Hospital's Values and Behaviours through a communications campaign.	Values & Behaviours Group (Sub Group of the Partnership Forum)	OD Manager / Head of Comms	November 2018	Complete A range of items were produced in addition to written communication. These included: a banner stand, mousemats, spectacle cloths, staff banner paper, stickers and posters.
09	Review and update of Security Notices.	Security Director	Physical Security Manager / Head of Comms	End March 2019	Complete These related to Dogs, Key Security, Mobile Phone Detectors, and Restricted Items.
10	Promote the launch of Staff and Volunteer 'Excellence Awards' through a communications campaign.	Values & Behaviours Group	OD Manager / Head of Comms	End June 2019	**New for 2019/20** This will include a banner stand, poster, logo, certificates, nomination boxes, and staff information.
11	Deliver a communications campaign to promote the launch of Staff Long Service Awards.	Values & Behaviours Group	OD Manager / Head of Comms	End June 2019	**New for 2019/20** This involves the production of certificates and badges for 20, 30 and 40 years' service.
12	Promote Manual Handling through a communications campaign.	Manual Handling Advisor	Manual Handling Advisor / Head of Comms	End August 2019	**New for 2019/20** A Display Screen Equipment (DSE) banner stand and patient information 'Manual Handling – Taking Care of Your Back' to be produced.
13	Directors to explore and implement opportunities for becoming more visible across the site.	iMatter	CEO / Directors	March 2020	**New for 2019/20** Specific action as this is a recurring theme from iMatter.

No	QI Objective	Source	Lead	Timescale	Status / New Timescale
			External Communications		
14	Undertake (and respond to) feedback from the annual Visitor Experience Questionnaire.	PCISG	PCIL	Ongoing	Complete As a result of carer feedback, a decision was made 2018/19, supported by SMT, to cease facilitation of this questionnaire. Feedback will continue to be sought through a range of methods including What Matters To You?, Carers' Week, social events and targeted questionnaires.
15	Explore measures to raise the Hospital's profile and address negative media reporting.	Comms	Chief Executive / Head of Comms	March 2019	Complete Meetings with Editors and the placing of features in appropriate magazines / journals was discussed. As in previous years, a decision was made not to progress at this time. Two letters were written to the Editor of the Daily Record (Nov 18 and Jan 19) with no response. Contact was made with the new Programme Director at See Me (Callum Irving) (Jan 19). Media Synopsis for January and February 2019 was produced for Board discussion following 21 published articles; most of these relating to an individual patient. Additionally in March 2019 the Board considered and subsequently declined a request for a documentary by the BBC.
16	Review the existing Patient Visitor communication resources.	What Matters To You initiative - June 2017	PCIL / Carers' Support Group (CSG)	March 2019	Complete Patient Visitor Information Pack produced March 2019.

No	QI Objective	Source	Lead	Timescale	Status / New Timescale
External Communications					
17	Produce a PCIS banner for the Patient Visitor Reception Area.	PCIS	PCIL / Head of Comms	End June 2019	**New for 2019/20**
18	Develop clinician recruitment marketing materials to take out to recruitment fairs.	Director of Nursing & AHPs	Head of Comms	March 2019	Complete Recruitment materials for registered and unregistered nursing staff have been developed by our Professional Nurse Advisor, and used at recruitment fayres during 2019. These have been developed at zero cost. State Hospital branded pull up banners have also been provided for these events, which are a shared resource for the Board.
19	Produce Media Lines for On-Call Directors.	Directors	Head of Comms	December 2018	Complete
20	Redesign and relaunch of State Hospital Website.	Board	Head of Comms	March 2020	On target
21	Ensure research is shared through the Website.	Board	Research & Dev Mgr Medical Director	March 2020	On target R&D Manager to provide web links to all confirmed publications and also include link to the Forensic Network Current Awareness Bulletin which includes details of all State Hospital Journal publications.
22	Create a new section on the State Hospital Website for Freedom of Information (FOI) Disclosure Logs and populate.	FOI legislation	Information Governance and Data Security Officer / Head of Comms	March 2019	Complete – new section. Ongoing – population.

No	QI Objective	Source	Lead	Timescale	Status / New Timescale
			Collaborative Working		
23	Align outputs arising from the recommendations of the internal audit (November 2015) relating to the efficacy of feedback processes, together with feedback from Scottish Public Services Ombudsman (SPSO), Scottish Health Council (SHC) and internal audit relating to complaints.	Internal and External Audits	PCIL (Feedback) Head of Corporate Planning and Business Support (Complaints)	March 2019	Complete
24	Facilitate What Matters To You? Initiative seeking the views of patients, carers and volunteers.	HIS	PCIL	Annual	Continues to be met every June
25	Be actively involved in the National Board Review Groups and work supporting the National Collaborative.	National Boards Collaborative	Head of Comms for Comms strand	As required	Continues to be met In Spring 2018 The State Hospital was part of group looking at efficiencies across four strands: Design, Media, Print Publishing, and Web. This included assessing options appraisals. This resulted in the production of a Publications Protocol for NHSScotland in November 2018. In January 2019 The State Hospital contributed to the development of the National Collaborative logo and engagement plan. **New for 2019/20** State Hospital features evidencing collaborative working to be produced Summer 2019 for the National Collaborative newsletter.
26	Explore a Memorandum of Understanding with another National Board as a means of strengthening resilience during any long-term absence.	National Boards Collaborative	Head of Comms / Chief Executive	Postponed to March 2020	On target Draft MoU produced for approval in July 2018 by the Golden Jubilee Foundation. Postponed pending recruitment of new GJF CEO and State Hospital CEO.

No	QI Objective	Source	Lead	Timescale	Status / New Timescale
			Collaborative Working		
27	With NHSScotland Comms colleagues to provide communications around EU Exit Preparedness.	Strategic Comms Group	Head of Comms	As required	Ongoing in parallel with local resilience planning.
28	Develop the leadership needs of NHSScotland Communications professionals: Directors of Comms and Heads of Service.	Strategic Comms Group	Strategic Comms Leadership Sub Group	December 2019	On target Sub Group comprises State Hospital Head of Comms and a member from Greater Glasgow and the Golden Jubilee. An audit of needs was undertaken in 2018 with 18 of the 22 Boards responding. Three key areas were highlighted for development: • How to persuade at senior management / board level. • Demonstrating value delivered by our teams. • How to build credibility of communications work across the organisation. Options are currently being explored to meet these particular needs.
			Equality, Diversity and Rights		
29	Undertake a scoping exercise relating to carer involvement in Care Programme Approach (CPA) review meetings / transfer planning process.	CSG	PCIL	April 2020	On target The Mental Health Practice Steering Group are supporting this piece of work. Timeframe is a three year plan as part of the Equality Outcomes workstreams.
30	Consult, publish and implement updated 2017/20 Equality Outcomes.	PCISG	PCIL	Every three years	Complete for 2017/18. Next update due April 2020.

No	QI Objective	Source	Lead	Timescale	Status / New Timescale
		Strategy / Policy			
31	Develop a Person Centred Improvement Service Delivery Plan.	Feedback from internal and external stakeholders	PCIL	July 2018	Complete
32	Produce a Supporting Patient Communication Policy.	Legislation, national drivers and local feedback	PCIL	March 2020	On target 50% complete.
33	Review Communications Resilience Risk Assessment (departmental risk register).	Risk Management	Head of Comms	December 2018	Complete This is subject to regular review.

7. OUTCOMES AND EFFECTIVENESS

The following are examples of positive outcomes evidencing effectiveness achieved during the year.

7.1 Patient / Carer / Volunteer Focus

- A Patient Engagement Workshop took place in October 2018 to review the Principles of the Clinical Model.
- A Patient Workshop was facilitated in February 2019 to elicit patient feedback as part of the review of the Clinical Care Model.
- Patients, carers and volunteers shared their feedback directly with the Mental Health Minister within the Stakeholder session of The State Hospital's 2018/19 Annual Review meeting (January 2019).
- The new information packs produced for patients, patient visitors and volunteers were positively received.
- The 2018 Carers' Week event produced consistent feedback relating to the value placed on engaging in socially inclusive events in the Hospital as well as understanding the therapeutic value of Skye Centre patient activities.
- The 2018 What Matters to You? Initiative was well supported throughout the Hospital with 31 of the 52 actions achieved by the end of the financial year.
- To meet GDPR legislative requirements, all patient, carer and volunteer information was reviewed and updated.

- Networking: Presentations / Workshops were delivered throughout the year to share best practice, address stigma and respond to national drivers on a range of topics including Spiritual & Pastoral Care, What Matters To You?, Volunteering including development of Impact Assessment Tool & Volunteer Visitor Programme, Person Centred Quality Improvement initiatives including flexible visiting and engaging hard to reach patients, Equality agenda including Protected Characteristics and Equality Impact Assessments.

- To ensure the Board has the opportunity to learn from the experience of patients, carers and volunteers, emotional touchpoint presentations regularly feature on the Board's agenda.

7.2 Internal Communications

- iMatter continues to have a good response rate – with results being shared with staff at all levels - and actions embedded within the Staff Governance Action Plan. The National Health and Social Care Staff Experience Report 2018 showed The State Hospital having achieved a response rate of 77% and we received a board report. The average response rate for NHSScotland was 59% for 2018, below the required 60% to produce a national report.

- Staff continue to contribute to the Staff Bulletin and Staff Newsletter 'Vision' which evidences success. Additionally, the Staff Bulletin ensures that all staff are well informed, no matter where they work or what their role is.

  - ✓ Internal and external events are advertised through the Staff Bulletin, Intranet and Email. As a result, high attendance at the following events, shows that these communication methods continue to work well: the weekly Journal Club, annual State Hospital Clinical Effectiveness & Research Conference, annual NHSScotland Event, health promotion events, learning opportunities, and general conferences and events internal and external. Additionally, a significant amount of lego was donated for a patient project following a request for same in the staff bulletin.

  - ✓ The staff bulletin continues to be a key communications tool to support the work of departments, groups and committees. For example, in terms of training opportunities promoted throughout the year:

    - o Further / Higher Education Bursary Award Scheme - applicants for 2018/19 sought (Apr 18) – there were 11 applicants of which seven were supported / approved.

    - o Further / Higher Education Bursary Award Scheme – applicants for 2019/20 sought (Mar 19) – seven applicants of which six were supported / approved.

    - o Staff Development Opportunity! Forensic Mental Health (SCQF Level 8) (Jan 19) – three applicants and all completed the course.

    - o Motivation, Action & Prompts (MAP) Training (Sep 18) – 11 staff attended / completed the course.

    - o New Turas Appraisal Tool – Awareness Sessions (Apr 18) – 32 awareness sessions delivered with 235 staff attending.

- ✓ The staff newsletter 'Vision' is used to provide feedback to staff on the aforementioned events and activities. It is also used to introduce staff through the regular 'Getting To Know Your' article. In 2018/19 over 20 staff appeared in Vision including a Non-Executive Director. These numbers don't include a feature which included around 20 members of staff in a photograph.

- Feedback arising from the policy consultation process (housed on the Intranet and advertised through the Staff Bulletin and Email system) evidences that staff are taking the time to read formal communications and respond. For example, there were: (1) 26 responses to the Patient Use of the Telephone Policy (some were collective, (2) six responses (including two collective) to the Palliative and End of Life Care Policy and Procedure, (3) four responses to the Food Fluid and Refusal Policy, (4) two responses plus one collective to the Unescorted Grounds Access Policy.

- Responses to Staff Engagement Exercises (issued by Email, housed on the Intranet and advertised through the Staff Bulletin) show that our electronic communications are well utilised by staff. For example, Clinical Model Principles in October 2018.

- Through dedicated communications staff were made aware of the financial pressure that the Board was experiencing in the year and measures that needed to be put in place to ensure year-end financial targets were met. As a result, our financial target for 2018/19 was met and were able to plan for sustainable service delivery in 2019/20 and onwards.

- Email is used to support staff with items sought or no longer required. This works very well.

- During January 2019, Communications assistance was given to the writing of poster abstracts for submission in respect of the NHSScotland Event 2019. This included researching the scoring criteria and subsequently developing a State Hospital staff information sheet providing guidance. Two of the Hospital's three abstracts were successful. This was a major achievement for the Board having not had an abstract accepted for many years.

7.3 External Communications

- Our State Hospital general presentation to local community groups continued to be received well. This is evidenced through our feedback forms which are extremely positive. Our presence in the local community leads to requests for further talks and helps to reduce stigma around mental health.

- Hosting visits to the Hospital ensures a wider audience learns about our work and enables the opportunity of sharing best practice and networking. Details of these visits are included in the Chief Executive's Report to each Board meeting.

- At each Board Meeting, the Chairperson provides feedback from the NHSScotland Chairs' Meeting. This ensures the Board is aware of what is happening nationally and includes updates on targets and priorities.

- An 'At a Glance' summary information sheet covering Key Performance Indicators (KPIs) was developed in December 2018 for the 2017/18 Annual Review in January 2019. This was the first time an 'accessible information sheet' had been produced and was positively received.

- Through the effective management of media enquiries, we were able to protect the Hospital's reputation by either (1) squashing what could have been a potential news story or (2) by lessening the impact of a negative story through rebutting inaccuracies and providing information to ensure fair and balanced coverage. Details of media enquiries / contacts are shared with Scottish Government colleagues and we often work together to ensure a joined up response by sharing lines etc.

- Every day we receive enquiries through the State Hospital's general email address: tsh.info@nhs.net.

- Freedom of Information (FOI) requests and general enquiries continue to be received through the general State Hospital email box (tsh.info@nhs.net) evidencing that this is not only effective but a popular resource.

- In 2018/19 a total of 24,304 people visited The State Hospital's Website; a slight increase from 21,161 in 2017/18. 77.7% were returning visitors. This shows that the Website is a good source of information and people are visiting again and again.

    - ✓ The most popular publications downloaded were About Us, Student Nurse Leaflet, Board Biographies, Safety and Security Requirements, and Restricted / Prohibited Items.

    - ✓ Our home page was the most popular page in 2018/19 (receiving 17,151 visits) followed by Jobs – 1,570, Contact Us - 873, Board Who's Who - 648, followed by Official Visitors, Public Safety, Board Papers and Patient Visitors.

8. SUMMARY

Given the nature and organisational arrangements of the Board, patients are uniquely viewed as internal communication stakeholders in addition to Non-Executive Directors, Volunteers, the Chaplaincy Team, Advocacy and staff. Carers, the public and the media are included within external communication arrangements.

The two services predominately delivering internal and external communications are the Communications Service and the Person Centred Improvement Service (PCIS) although the Intranet is managed by eHealth.

Overall, core Communications tasks were delivered, all legislative requirements were met, and all financial targets / savings were achieved. However more needs to be done:

- To review the functionality / effectiveness of the Intranet which is currently unsupported by Microsoft.
- To address negative media reporting and to raise the profile of The State Hospital (both within and outwith NHSScotland) with all stakeholders including regulators, partner organisations, the public, the media etc. Disappointingly, as in previous years, some negative coverage has been initiated via leaks by staff to the media. Attempts to source these individuals have been unsuccessful.

These issues should in no way detract from the good work that has taken place across all strands of communications, both internal and external, attracting positive attention.

June 2019

Paper No: 19/65

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 August 2019
Agenda Reference:	Item No: 21
Sponsoring Director:	Chief Executive
Author(s):	Board Secretary
Title of Report:	Corporate Governance Improvement Action Plan
Purpose of Report:	For information

1 SITUATION

Following Board self-assessment, an improvement plan was developed to support key corporate governance priorities as part of the Corporate Governance Blueprint.

The Board submitted its improvement plan to Scottish Government in April 2019.

2 BACKGROUND

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

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

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 in corporate documentation. A competition was held in the hospital, and the following strapline has been developed and implemented: *Safe and Secure, Care and Treatment*. [Refer to Action Point 1]

The Board will receive an update on a review of the performance framework presented to the Board separately on today's Board Agenda at Item 17. [Refer to Action Point 7]

Work is on track in relation to attendance management with a roll out of training sessions to Human Resources officers as well as line managers across the organisation, which commenced in June and is ongoing. This is alongside focus on the ongoing roll out of the national HR policy framework. [Refer to Action Point 5]

There has been significant progress made to implement a staff recognition scheme, and the first staff awards ceremony will take place in the Skye Centre on 25 September 2019. It is of note that this venue has been chosen as enables attendance by patients who have been able to participate in nominating staff. All Board Members are welcomed to attend the ceremony. In the meantime, some awards for long service to the NHS have already been presented to individuals by the Chief Executive. [Refer to Action Point 16]

The Board is asked to note that it is proposed that the next meeting of the Board in October should take place outwith the hospital, at an external location in the local area to support accessibility and engagement with the wider public. [Action Point 16].

Senior Management visibility through regular front line staff engagement with the Chief Executive and the wider Executive cohort has been promoted through the Lead for Organisational Development. The Chief Executive has met with a range of staff groups through attendance at their business meetings. The second phase of this engagement will be a roll out of engagement sessions with the wider Executive cohort commencing in October 2019. This is in conjunction with the specific measures outlined within the Board's response to the Sturrock report. [Action Point 18]

Non-Executive Board Members wish to increase their own visibility on site. However, the secure environment of TSH means that this is a more complex undertaking than for NHS Boards more generally, particularly in relation to engagement with patients. [Refer Action Point 21]. The Board Secretary will plan and implement the following suggested routes to help to increase Non-Executive Director visibility across TSH.

The most appropriate route for patient engagement is through the Patient Partnership Group which meets regularly on Monday mornings. The Person-Centred Improvement Lead will support Non-Executive's attendance at these meeting and can be a helpful route through which to ascertain patient feedback in this regard to help monitor the effectiveness of the engagement experience.

The Chair and the Non-Executive Directors already participate in Leadership Walkrounds in the hospital and this formal role should still be supported as a priority. In addition, Non-Executives have committed to increasing their visibility within TSH through attendance at hospital events and use of hospital facilities such as the canteen regularly. To support further engagement in clinical areas, Non–Executives will be invited to participate in clinical walkrounds that take place regularly led by the Medical Director and Director for Nursing and AHPs. As access to clinical areas can present challenges, it is important that this be tested over the coming months for appropriateness and effectiveness.

The Chair and Non-Executives are also invited to participate in staff induction sessions – to help welcome new staff coming in to the organisation, outlining TSH aims and values. A programme will be rolled out in line with the staff induction programme.

4 RECOMMENDATION

The Board is asked to note progress in implementation of the improvement plan, and to discuss the progress made to date as well as further suggested routes to take the action plan forward.

A further update will be brought to the next meeting of the Board in October 2019.

Paper No: 19/65

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	**Completed:** Strapline finalised following hospital wide competition. Strategy Map reviewed 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 Attendance Management Improvement Task Group (AMITG).	Interim HR Director	AMITG/ SMT	October 2019	On Track. Training for Line Managers and HR Managers implemented in June and July, with further sessions ongoing. Update presented on attendance management to each Board Meeting.

	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 – following roll out of the national guidance.
	7	Review performance framework and assurance information systems to support review of performance.	CEO	CEBM	July 2019	Update to August 2019 Board Meeting.
	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 – October 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	Interim HR Director	SMT	March 2020	Ongoing – engagement commenced in university recruitment fairs. Recruitment Fair at TSH in September 2019

		events, local and university recruitment fairs				(Outwith secure area to enable public engagement).
	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	On Track - 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	On Track - 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	CEO	SMT	July 2019	CEO Business Meetings venue held weekly across site, for visibility. CEO attending staff groups across site. OD Lead

		- plan a calendar of events to ensure regular engagement.				supporting wider engagement plan for Exec Leads commencing October 2019.
	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	Coordination of 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	National Recruitment underway
	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, with planned schedule including walkrounds, staff induction and patient engagement.

Board Paper 19/66

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 August 2019
Agenda Reference:	Item No: 22
Sponsoring Director:	Chief Executive
Author(s):	Board Secretary
Title of Report:	Annual Review Outcome Letter
Purpose of Report:	For Noting

1 SITUATION

The Minister for Mental Health has written to the Board Chair to summarise the key points from the Annual Review 2017/18, which took place at The State Hospital on 14 January 2019.

2 BACKGROUND

The purpose of the letter (Appendix A) from the Scottish Government is to inform the Board of the outcome of the 2017/18 Annual Review. The letter provides a summary of the main points of discussion and actions arising from the review.

3 ASSESSMENT

The Board should note the summary provided in relation to the meetings that took place as part of the review with the Clinical Forum, the Partnership Forum and with Patients, Carers and Volunteers.

The letter provides an update on the progress made by the Board in relation to the actions arising from the 2016/17 Annual Review; as well as setting out the actions arising from the 2017/18 Annual Review.

The Board has not yet been notified of the date of the 2018/19 Annual Review – an update will follow in this regard, once this is available.

4 RECOMMENDATION

The Board is invited to note this update.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Update information only
Workforce Implications	As detailed within report
Financial Implications	Not relevant
Route To Board Which groups were involved in contributing to the paper and recommendations.	Board requested information
Risk Assessment (Outline any significant risks and associated mitigation)	Not required
Assessment of Impact on Stakeholder Experience	As detailed within report
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).	This is not relevant
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One √ There are no privacy implications. □ There are privacy implications, but full DPIA not needed □ There are privacy implications , full DPIA included.

Minister for Mental Health
Clare Haughey MSP

Scottish Government
Riaghaltas na h-Alba
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Mr Terry Currie
Chair, The State Hospitals Board for Scotland
The State Hospital
Carstairs
Lanark
ML11 8RP

18 June 2019

Dear Terry

I am writing to summarise the main points from the 2017/18 Annual Review at the State Hospital on 14 January 2019. Following the format from last year, this letter provides a brief summary of the key points from the Annual Review, progress on actions from the 2016/17 Review and agreed actions for 2018/19.

Clinical Forum

I welcomed the update on how the Clinical Forum has established itself since 2017 and its ongoing work. In particular, I was pleased to hear about the TSH3030 quality improvement initiative, which has engaged staff and delivered improvements across the Hospital, and the ongoing work to review the clinical model, in consultation with patients and staff.

The Mental Welfare Commission for Scotland's report following their visit to the Arran and Mull hubs on 30 August 2018 noted that there were not sufficient staff to ensure provision of activities in line with patients' need. I welcome the recent recruitment of staff to the Hospital, with further recruitment to take place shortly, and I was also pleased to hear about the Patient Active Day project, which aims to increase patient participation in activities despite challenging circumstances, and some additional out-of-hours activities at the request of patients. I look forward to hearing how the new staff and increased focus on activities lead to further participation by patients in the future.

The physical health of patients is a crucial part of their care and treatment, so I was encouraged to hear about the Primary Care team within the Hospital and the improved liaison and handover processes with Wishaw General Hospital for offsite treatment. I was also interested in the various ongoing measures to tackle obesity – I look forward to hearing how effective these measures are over time and how their impact is assessed. I would encourage the Clinical Forum to consider having the Primary Team represented on the Forum and to further broaden connections with other clinicians and organisations outside of the Forensic Network.

Partnership Forum

I was encouraged to hear that both management and staff-side representatives are committed to partnership working, particularly given some of the challenges presented in 2018.

As in the Clinical Forum, I welcomed the recent recruitment of staff, along with further imminent recruitment, which will provide more staffing flexibility and reduce pressure on existing staff. The plans to encourage newly-qualified nurses to work at the Hospital were interesting, particularly given the number of current staff who are approaching retirement age.

Given the historically high levels of sickness absence at the Hospital, I was pleased to hear about the reformation of the Attendance Management Group, the various measures in place to tackle sickness absence levels and the ambition to reduce sickness absence by 3% by the end of 2018/19.

Regarding leadership, there were a number of positive steps including an increase in the number of senior charge nurses, a new development course for existing senior charge nurses and a National NHS Board collaboration project on development for managers.

I look forward to seeing the effects that all we discussed have on standards of patient care, patient and staff safety, overtime and sickness absence levels.

Meeting with Patients, Carers and Volunteers

It was a privilege to meet with patients, carers and volunteers as part of the Review and I wish to thank them again for giving their time to meet with me.

The patients I met were involved in representing patients on different groups and boards, evidencing positive engagement and a willingness from the Hospital to involve patients in decisions that affect them. The patients spoke positively about the staff, volunteers, social events, family visits and activity placements at the Skye Centre, but raised issues with staff continuity and familiarity, having to remain in their rooms during periods of reduced staffing and not being more involved in the types of activities that were planned.

The carers I met also praised the staff and the work done at the Hospital, although they raised frustrations with having to travel long distances for meetings at the Hospital which are scheduled early in the morning, necessitating travelling the day before and staying overnight.

The two volunteers shared their experiences of visiting patients who would otherwise have no visitors at all and highlighted the positive effect that this has on the patients, particularly those who are extremely unwell.

I look forward to the Board increasing engagement with patients, carers and volunteers and handling the issues raised by them. In particular, I'm interested in how they might use technology to solve issues such as carers travelling long distances to visit patients and attend meetings.

Actions

I have set out the progress on action points from 2016/17 Annual Review in the attached Annex A – further detail on all of the points is provided in your Self-Assessment document which has been published on your website. Annex B lists the action points arising from the 2017/18 Annual Review. While I appreciate the delay is inconvenient, the actions in Annex B were discussed in depth on the day of the Annual Review and I recognise that State Hospital management are already looking at these matters. I look forward to hearing about the progress that has already been made in 2018/19.

In closing, I would like to thank all of the staff, patients, carers and volunteers that I met for being generous with their time. In particular, I'd like to extend my thanks to the Board Secretary, Margaret Smith, for organising the Annual Review programme, especially the impromptu ward visit that was arranged on the day.

Since the Annual Review took place, I note that Gary Jenkins has been appointed to the post of Chief Executive. I look forward to working with Mr Jenkins and I'd like to thank outgoing Chief Executive Jim Crichton for his service. Additionally, Terry Currie's appointment as Board Chair has been extended to provide continuity as Mr Jenkins takes up his post and to assist with the Scottish Government's review for forensic mental health services across Scotland. I thank Mr Currie for agreeing to remain in post for a further 12 months while this crucial work is carried out.

Clare Haughey

ANNEX A

The State Hospital Annual Review 2017/18 – Progress on Actions from 2016/17 Review

1. The State Hospital to keep Health Directorates up to date on progress in partnership working.

    - Both management and staff-side representatives remain committed to partnership working, although staffing levels, sickness absence, informal action and negative media coverage have been challenging. Achievements include the cap on overtime, recruitment of staff to a flexible nursing pool and consultation on a new Clinical Model.

2. The State Hospital to keep the Health Directorates up to date on improving the physical wellbeing of patients, particularly on work to support patients in relation to diet and obesity.

    - Physical health remains a challenge, but staff upskilling to improve this is in progress and better connections with the local hospital are in place for offsite care. Various measures are in place to reduce obesity among patients and their effectiveness should be closely monitored.

3. The State Hospital to keep Health Directorates up to date on action to address reducing the levels of aggressive incidents by patients.

    - All high-graded incidents are regularly reviewed and a new risk assessment tool is in place across wards. A small number of patients are often responsible for a large number of assaults, so there should be focus on handling this. Staff training on preventing and managing violence and aggression is ongoing and uptake should increase following recruitment of new staff.

4. The State Hospital to keep Health Directorates up to date on action to improve performance in relation to sickness absence and on further work on value and behaviours.

    - Further focus on sickness absence is needed to reduce it, particularly in order to meet the 3% reduction target set by the State Hospital for the end of 2018/19. The effectiveness of the various measures in place should be closely monitored.

5. The State Hospital to continue to keep Health Directorates up to date on all matters relating to media activity and any correspondence with patients and families and/or carers which may require government officials and/or Ministers to become involved.

    - During the reporting period 1 April 2017 to 31 March 2018, no media activity or correspondence required Scottish Government officials or Ministers to become involved. However, there was significant negative media coverage in the second half of 2018. The State Hospital continue to keep officials up to date with the media queries they receive and their responses to these.

6. The State Hospital to liaise with the Health Directorates on succession planning for key senior roles.

    - The Board informed Scottish Government officials of various upcoming changes to senior posts. Effectiveness of handover to new staff should be monitored closely.

ANNEX B

The State Hospital Annual Review 2017/18 – Action Points for 2018/19

1. The State Hospital to keep the Scottish Government up to date on partnership working.

2. The State Hospital to keep the Scottish Government up to date progress to improve the physical health of patients.

3. The State Hospital to keep the Scottish Government up to date on progress to reduce the levels of aggressive incidents by patients.

4. The State Hospital to keep the Scottish Government up to date on progress to reduce levels of sickness absence.

5. The State Hospital to keep the Scottish Government up to date on all matters relating to media activity and any correspondence with patients and carers which may require government officials and/or Ministers to become involved.

6. The State Hospital to keep the Scottish Government up to date on succession planning for key senior roles, particularly the new Chair and Chief Executive.

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 Mazzucco 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

Minutes of the meeting of the Audit Committee held on Thursday 20 June 2019 at 12.30pm in the Boardroom, The State Hospital, Carstairs.

PRESENT:

Non-Executive Director	Bill Brackenridge
Employee Director	Tom Hair
Non-Executive Director	David McConnell **[Chair]**
Non Executive Director	Maire Whitehead

IN ATTENDANCE:

Internal

Board Chair	Terry Currie
Chief Executive	Gary Jenkins
Finance and Performance Management Director	Robin McNaught
Head of Corporate Planning and Business Support	Monica Merson
Board Secretary	Margaret Smith

External

Partner, Scott Moncrieff	Chris Brown
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. There were no apologies to be noted.

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 28 March 2019 were approved as an accurate record, subject to one minor amendment.

APPROVED

4 MATTERS ARISING AND ACTION NOTES UPDATE

Progress was noted on the Minute action points and it was agreed that a further update should be brought to the next Audit Committee in relation to Action Point 6 “Policy Update” in respect of testing engagement through the policy consultation process.

Action – Ms Merson

NOTED

5 INTERNAL AUDIT PLAN

Mr Mazzucco presented an update to Members on the Internal Audit Plan and Updated Strategy for 2019/20, highlighting the changes that had been made in response to the discussion and request to do so at the last meeting of the Audit Committee. These changes were summarised as now involving consideration of payroll policies and procedures in Quarter 2 and review of sickness and absence management in Quarter 3. There would be a short follow–up review of Patient Funds and Property in Quarter 2.

Members also discussed the review of the implementation of the Clinical Model planned in Quarter 4, and whether the timing of this would align with the progress of the Model's development and implementation. Subject to the Board approving the introduction of a new clinical model this year, it was agreed that the audit plan should reflect that this would be a review focused on the process of introducing a new model, rather than on final implementation as this was likely to be in progress during Quarter 4.

The Internal Audit Plan was approved on the basis of the updates provided.

APPROVED

6 INTERNAL AUDIT 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. It was noted that a key area of focus for improvement was in Risk Management, and this was a key area for improvement.

Significant progress had been made within Policy and Procedure Compliance and Sickness and Absence Management. The Committee queried the action point on the requirement to return a self certificate within 7 days of the first day of absence and asked for the Interim Director of HR to clarify this point. Ms Smith would request this on the Committee's behalf.

Action – Ms Smith

It was also noted that The State Hospital (TSH) would take forward the action tracker software in a trial to help in the administration and managing of internal audit action points. Ms Merson would take this forward.

Action - Ms Merson

Members noted that it was essential for the timeframes for moving actions forward were reasonable and achievable and this should be an area of focus for the organisation. In particular it was noted that the actions for Cyber Security, although rated low had been outstanding since March 2018. Mr McNaught assured the Committee that these would be completed before the next Audit Committee.

Action – Mr Mc Naught

NOTED

7 CLINICAL GOVERNANCE COMMITTEE – ANNUAL REPORT 2018/19

The Audit Committee now received a series of reports from the State Hospital's key governance committees, which support its overall consideration of governance arrangements across the organisation.

The Committee received the annual report from the Clinical Governance Committee for 2018/19, and agreed that this detailed report provided assurance that the Committee was fulfilling its remit, and that adequate and effective clinical governance arrangements were in place throughout the year.

NOTED

8 STAFF GOVERNANCE COMMITTEE - ANNUAL REPORT 2018/19

The Committee received the annual report from the Staff Governance Committee for 2018/19. The Chair of the Staff Governance Committee, Mr Brackenridge, summarised this for Members who were noted the report provided assurance that the Committee was fulfilling its remit and that adequate and effective staff governance arrangements were in place throughout the year.

The Board Secretary was asked to make an amendment to the report on page three (the number of meetings) to clarify that the Committee had also met on 5 April 2018. This meeting had originally been scheduled to take place in March 2018 and required to be re-scheduled due to inclement weather.

Action – Ms Smith

NOTED

9 REMUNERATION COMMITTEE – ANNUAL REPORT 2018/19

The Committee received the annual report from the Remuneration Committee for 2018/19. The Chair of the Committee, Mr Currie, provided an overview of this report which demonstrates that the Committee has discharged its responsibilities. The Board secretary was asked to make some minor amendments to the dates of the meetings held as well as to note a change in membership with Ms Carmichael having retired and Mr McConnell having joined the Board as a Non – Executive Director.

It was also noted that the report should be amended to reflect that the Remuneration Committee provides aspects of reporting through the Audit Committee, but that its direct reporting line is to the Board.

Actions – Ms Smith

On this basis, the Audit Committee were content to note the report.

NOTED

10 AUDIT COMMITTEE - ANNUAL REPORT 2018/19

The Audit Committee received its Annual Report for consideration and approval. As Chair, Mr McConnell provided an overview of the report and Members were content to approve the report as giving assurance that the Committee had met its remit and was satisfied that internal controls are adequate to ensure that the Board can achieve its policies, aims and objectives.

APPROVED

11 NATIONAL SINGLE INSTANCE (NSI) AND NSS SERVICE AUDITS

The Committee received a report to provide an update on the service audits carried out on the NSS National IT Services Contract and NSI finance system. There was nothing of specific impact for TSH from the National Service audit in the year for IT services from which no significant control issues were raised.

There was also an audit on the National Single Instance finance system (which was noted to be delivered through NHS Ayrshire and Arran as host board) from which again there were no control weaknesses noted of relevance to TSH.

These were both unqualified opinions from the Service Auditors, with no critical or significant risk findings for TSH.

NOTED

12 AUDIT SCOTLAND NATIONAL REPORTS

The Committee received a report to provide an update of the recommendations made following publication of Audit Scotland National Reports, and in particular the report "NHS in Scotland". Members noted the content.

NOTED

13 EXTERNAL AUDIT ANNUAL REPORT -2018/19

The Committee received a report from Scott Moncrieff for the year ending 31 March 2019. Mr Brown led Members through the detail of the report, highlighting that the Board had achieved all of the key objectives within financial sustainability, financial management, governance and transparency as well as value for money. The auditor's report was unqualified in all respects. No major new risks had been identified and the key risks of managing sickness absence and overspends on nursing overtime continued to present a significant challenge to the Board's financial position.

Mr Brown gave particular thanks to the Finance Team for their work which had been of a particularly high quality. Ms Jones provided a detailed overview of the audit of the annual accounts, noting no material audit adjustment to the financial statements. She also outlined the key areas for the external audit plan as being management of sickness absence and overspend on nurse overtime.

Ms Jones re-confirmed Scott Moncrieff's position as independent auditors.

Members thanked Scott Moncrieff for their report and noted that an amendment was required to wording on page 31 under the recommendation for the Board on the Asset Register.

Action - Scott Moncrieff

The Committee noted the key messages form the report, and also that there should be continuing consideration of the balance between recurring and non-recurring savings, and that this report provided timely and appropriate recognition of this. Mr McNaught provided assurance that this would be reviewed as appropriate.

Action – Mr McNaught

The Audit Committee noted the content of this report.

NOTED

14 STATUTORY ANNUAL ACCOUNTS

The Committee received the Board's Annual Accounts, presented in the format directed by the Scottish Government.

Mr McNaught provided a detailed summary, and highlighted some minor amendments to be made. He thanked the Finance Team for their excellent work, and acknowledged the recognition of this from the external audit report, which would be cascaded to staff. Mr McNaught advised that the report and accounts had been reviewed in full by Scott Moncrieff as external audit, from whom an unqualified audit opinion had been given.

Mr McNaught advised that the Performance Report gave the main financial indicators, and confirmed that the Board was within budget for its revenue and capital limits. He outlined the Accountability Report including the Corporate Governance Report and the statutory compliance statement with regard to Chief Executive responsibilities – the format showing no change from prior years. There were some minor amendments noted for the number and attendance at governance Committees and this was agreed by Members as previously noted in the annual reports of each Governance Committee.

Mr McNaught highlighted the Governance Statement which covered internal controls and risk assessment, and detailed the governance committees, and noted that the overall structure and wording remained similar to previous years.

The report detailed the remuneration for the year for senior staff, and which included a new disclosure highlighting where we will publish Trade Union information on the Board's website. Mr McNaught also detailed the principal financial statements – Statement of Comprehensive Net Expenditure, Summary of Resource Outturn, Statement of Financial Position (formerly the Balance Sheet), Cashflow Statement and Statement of Changes in Taxpayers' Equity - showing the breakeven revenue position.

Mr McNaught advised that Mr Jim Crichton, on retiring from his role as Chief Executive Officer at the end of March 2019, had written a Letter of Assurance to Mr Gary Jenkins on governance for the financial year ending 31 March 2019. This assurance would allow Mr Jenkins to sign the annual accounts for the year 2018/19.

It was noted that a change may be required to the register of interests by the Medical Director, who would be asked to clarify and make any appropriate amendment required.

Subject to the minor amendments required, the Audit Committee recommended that the report on the annual accounts for the year ended 31 March 2019 be submitted to the Board for consideration and approval.

APPROVED

15 ANNUAL AUDIT COMMITTEE ASSURANCE STATEMENT

The Committee received a report recommending that it provides the Board with a statement of assurance to allow the approval for signing of the Performance Report, the Accountability Report as well as adoption of the Annual Accounts for the year ending 31 March 2019.

It was noted that the Committee had received and considered the annual Internal Audit Report as well as reports and assurances from the Director of Finance and Performance Management and the Chief Executive Officer. The Audit Committee had also received the annual reports from the Clinical Governance Committee, the Staff Governance Committee and the Remuneration Committee.

Members noted the minor amendments required to the governance committee annual reports as well as the annual accounts and on this basis, were content to provide the Board with a statement of assurance.

The Audit Committee recommended that the Board adopt the Annual Accounts for the year ended 31 March 2019 and approve submission to the Scottish Government Health and Social care Directorate.

The Audit Committee recommended that the Board authorises the Chief Executive to sign the Performance Report; that the Chief Executive to sign the Accountability Report; and that the Chief Executive and the Director of Finance and Performance Management sign the Statement of Financial Position.

APPROVED

16 PATIENTS FUNDS ACCOUNTS

The Committee received a report from the Director of Finance and Performance Management for Patients Funds Annual Accounts to the year ending 31 March 2019 – this relating to the balances of money held by TSH on behalf of patients. The report had been audited by Wylie and Bisset as external auditors which had provided an unqualified with one audit recommendation raised by this year's review which was noted as being addressed.

It was noted that in the future, the full report should be included within the papers. The full financial statement was circulated at the meeting today to ensure that Members had sight of this.

Action – Mr McNaught

The committee noted that the Patients Funds Accounts require to be approved by the Board and were content to recommend to the Board that it should give the Director of Finance and Performance Management and the Chief Executive approval to sign the summary income and expenditure statement.

APPROVED

17 WAIVER OF SFIs TENDERING REQUIREMENTS

The Committee received a report from the Director of Finance and Performance Management, to outline any instance during 2018/19 whereby the Chief Executive and Director of Finance and Performance Management have agreed to waive the requirement for competitive tendering or quotations should they jointly agree that it is not possible or desirable to undertake same having regard for all circumstances, and in accordance with Standing Financial Instructions (SFIs).

The Committee were asked to note that each case was closely reviewed to ensure that the use of a waiver was valid. There were no items this year for which this process was not followed when it should have been.

It was noted that in future, should the value of the service received vary from the waiver as signed, then a note to that effect should be added to this report. The Committee noted the report, as approval lies appropriately with the Chief Executive Officer as Accountable Officer for the Board.

NOTED

18 FRAUD UPDATE

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

Four alerts had been issued since the last report and these were summarised within the report. All incidents reported to CFS with regard to fraud matters in 2018/19 were closed, concluded satisfactorily with no further action required, and the Head of Service at CFS presented the Board with his annual update in March 2019.

The Committee noted the report, and agreed that it would be appropriate for the Committee Chair to write to Scottish Government to provide assurance that there had been no significant issues during the year ending 31 March 2019.

Action – Mr McNaught

NOTED /APPROVED

19 FRAUD ACTION PLAN

The Committee received and noted the paper which provided an update on Board engagement with Counter Fraud Services (CFS). The Committee noted the report and the progress made.

NOTED

20 SUMMARY OF LOSSES AND SPECIAL PAYMENTS

The Committee received a report from the Director of Finance and Performance Management, which provided an annual review of the Board's register of losses and special payments.

The Committee were content to note the report.

NOTED

21 ANY OTHER BUSINESS

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

NOTED

22 DATE AND TIME OF NEXT MEETING

The next meeting would take place on 10 October 2019 in the Boardroom, The State Hospital, Carstairs.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 August 2019
Agenda Reference:	Item No: 24
Sponsoring Director:	Board Chair
Author(s):	Board Secretary
Title of Report:	Annual Schedule of Board and Sub Board Meetings – 2020
Purpose of Report:	For approval

1 SITUATION

The draft Annual Schedule of Meetings for Board and Sub Board Committees in 2020 is attached.

2 BACKGROUND

The Board requires to agree the schedule of meetings for 2020, and to make the dates of the Board Meetings publically available on its website.

3 ASSESSMENT

There are no proposed changes to the usual pattern of the schedule for Board and Committee Meetings in 2020.

4 RECOMMENDATION

Members are asked to approve the attached Annual Schedule of Meetings for 2020.

The State Hospital

ANNUAL SCHEDULE OF MEETINGS - 2020
BOARD AND SUB-BOARD

MEETING	Chair/ Members	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEPT	OCT	NOV	DEC
BOARD	**Terry Currie*** B Brackenridge T Hair N Johnston D McConnell M Whitehead		Thursday 27.02.20 9.45am Boardroom		Thursday 23.04.20 9.45am Boardroom		Thursday 25.06.20 12.30pm Boardroom		Thursday 27.08.20 9.45am Boardroom		Thursday 22.10.20 9.45am Boardroom		Thursday 17.12.20 9.45am Boardroom
AUDIT COMMITTEE	**D McConnell*** B Brackenridge T Hair M Whitehead	Thursday 23.01.20 9.45am Boardroom		Thursday 26.03.20 9.45am Boardroom			Thursday 25.06.20 9.45am Boardroom				Thursday 08.10.20 9.45am Boardroom		
CLINICAL GOVERNANCE COMMITTEE	**N Johnston*** D McConnell M Whitehead		Thursday 13.02.20 9.45am Boardroom			Thursday 14.05.20 9.45am Boardroom			Thursday 13.08.20 9.45am Boardroom			Thursday 12.11.20 9.45am Boardroom	
STAFF GOVERNANCE COMMITTEE	**B Brackenridge*** T Hair N Johnston M Whitehead		Thursday 20.02.20 9.45am Boardroom			Thursday 21.05.20 9.45am Boardroom			Thursday 20.08.20 9.45am Boardroom			Thursday 19.11.20 9.45am Boardroom	
RENUMERATION COMMITTEE **	**T Currie*** B Brackenridge T Hair N Johnston D McConnell M Whitehead		Thursday 27.02.20 2.00pm Boardroom				Thursday 25.06.20 3.30pm Boardroom				Thursday 22.10.20 2.00pm Boardroom		

* Chair of Committee
** Remuneration Committee also meets as and when required

2020

PUBLIC HOLIDAYS:
New Year : Wednesday 1 January & Thursday 2 January
Christmas : Friday 25 December & Monday 28 December
Easter : Friday 10 April & Monday 13 April
Autumn Holiday : Friday 25 September & Monday 28 September