THE STATE HOSPITALS BOARD FOR SCOTLAND

BOARD MEETING

THURSDAY 13 DECEMBER 2018
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 25 October 2018	For Approval	TSH(M)18/12
4.	**Matters Arising:**		
	Actions List	For Noting	Paper No. 18/79
5.	**Chair's Report**	For Noting	Verbal
	CLINICAL GOVERNANCE		
6.	**Person Centred Involvement Team – Annual Report** Report by the Director of Nursing and AHPs	For Noting	Paper No. 18/80
7.	**Patient Advocacy – Annual Report** Report by the Director of Nursing and AHPs	For Noting	Paper No. 18/81
8.	**Clinical Forum – Update** Report by the Chair of the Clinical Forum	For Noting	Paper No. 18/82
9.	**TSH 3030** Report by the Head of Corporate Planning and Business Support	For Noting	Paper No. 18/83
10.	**Clinical Governance Committee** Chair's Report - Meeting 15 November 2018	For Noting	Verbal
	STAFF GOVERNANCE		
11.	**Attendance Management Task Group – Update** Report by the Interim Director of HR	For Noting	Paper No. 18/84

12.	**Staff Engagement - CEO Sessions** Report by the Chief Executive	For Noting	Paper No. 18/85
13.	**International Training Proposal** Report by the Interim Director of HR	For Approval	Paper No. 18/86
14.	**Staff Governance Committee** Chair's Report – 29 November 2018	For Noting	Verbal

CORPORATE GOVERNANCE

15.	**Finance Report to 30 November 2018** Report by the Director of Finance & Performance Management	For Noting	Paper No. 18/87
16.	**Service Sustainability and Transformation Update** Report by the Director of Nursing & AHPs	For Noting	Paper No. 18/88
17.	**Performance Report** Report by the Director of Finance & Performance Management	For Noting	Paper No. 18/89
18.	**Information Governance Report** Report by the Director of Finance & Performance Management	For Noting	Paper No. 18/90
19.	**Annual Review – Update** Report by the Board Secretary	For Noting	Paper No. 18/91
20.	**Audit Committee** Draft Minutes of meeting held 20 September 2018	For Noting	A(M) 18/04
21.	**Chief Executive's Report**	For Noting	Paper No. 18/92
22.	**Board Workplan 2019** Report by the Board Secretary	For Approval	Paper No. 18/93
23.	**Any Other Business**		
24.	**Date and Time of next meeting** 28 February 2019, 9.45am in the Boardroom At The State Hospital, Carstairs, ML11 8RP		

25. 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)18/12***

Minutes of the meeting of The State Hospitals Board for Scotland held on Thursday 25 October 2018 at 9.45am in the Boardroom, The State Hospital, Carstairs.

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

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

Mr Currie welcomed everyone to the meeting, and noted apologies from Mr Bill Brackenridge, Mrs Anne Gillan and Mrs Kay Sandilands.

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 23 August 2018 were noted to be an accurate record of the meeting.

APPROVED

4 ACTION POINTS AND MATTERS ARISING FROM PREVIOUS MEETING

The Board noted progress on the action points from the last meeting. It was noted that a report on

staffing compliment would be remitted to the Staff Governance Committee.

NOTED

5 CHAIR'S REPORT

Mr Currie provided Members with an update from the NHSScotland Board Chairs meeting which had taken place on 24 September 2018.

There had been discussion around the Health and Social Care (Staffing) Bill which related primarily to nursing – to introduce specific tools to assist in ensuring an appropriate number of staff to fulfil functions. It had been noted that there would be a need to retain flexibility to accommodate local needs.

It was the first meeting with the new Cabinet Secretary for Health and Sport, Ms Jeane Freeman, and she emphasised her four main areas of priority as being waiting times, an increase in the pace of the implementation of health and social care integration, mental health for children and young adults and board governance. The Cabinet Secretary's highlighted the 'Once for Scotland' approach and the need for NHSScotland to act as one organisation. The Cabinet Secretary's focus was on the need to tackle the short term issues that NHSScotland currently faces, before moving on to longer term strategic issues. She also noted the decision made around brokerage for Boards, and underlined the need for Boards to reach financial balance for year end as a priority.

Mr Currie provided Members with an overview of the Chairs Away Day on 11 and 12 of October 2018, where the focus had been on governance. The Blueprint for Governance had been circulated to Members and Mr Currie confirmed that an update report would come to this Board at the December Meeting.

Action – Ms Smith

Mr Currie confirmed that a Ministerial Review visit would take place at The State Hospital on 14 January 2019, and that arrangements would also be made for a separate public meeting. This would be discussed at Item 17 in this meeting.

Progress was being made in the recruitment of a Chief Executive for The State Hospital, and an interview date had been set for 6 December 2018. In addition, interviews for a new Chair would take place through the Public Appointments Unit week beginning 11 November 2018.

Mr Currie noted the questionnaire issued in relation to Diversity in Research which was to be completed by 2 November.

NOTED

6 SAFETY REPORT

A report was received from the Medical Director, which outlined progress on work to date on examining issues of safety within The State Hospital. This work had flowed from the results of a staff survey on Culture and Readiness for Change.

Professor Thomson provided members with a detailed overview of the main findings of the work. In doing so, she thanked Ms Merson and her team for the level of business support provided.

Professor Thomson led Members through the aims of the work, as well as the methodology and restrictions experienced in collating data for analysis. She highlighted that the evidence did not indicate a linear increase in the number of assaults, and that a very small number of patients were carrying out multiple assaults. Although significant rates were found within patients with Intellectual

Disorder (ID), most assaults were carried out by patients in the mental health population. The data also evidenced that most assaults occurred when patients were in the rehabilitation phase, rather than the admissions phase of their care pathway.

The report outlined three possible hypotheses. The first hypothesis was that TSH is dealing with more prisoners with antisocial behaviour who would carry out assaults. However, the data evidenced no association with being from a prisoner background as defined by a transfer for treatment direction or prison admission source and carrying out assaults as compared to other groups within the hospital.

The second hypothesis was that the use of Novel Psychoactive Substances (NPS) by patients is leading to more aggressive behaviours. Further research would be required to investigate this.

The third hypothesis was that patients were “sicker” (more psychotic) than they used to be. There was no pattern in the data for patients who carry out multiple assaults. Further research would be required into the mental state of patients comparing those who assault with those who do not.

The report made the following recommendations:

- A small number of patients (2-3 in 2017-18) carried out the majority of assaults. Consideration should be given to the creation of a high dependency unit to meet their needs.
- A Complex Case Review should be carried out if there are three or more episodes of assault by a patient in a rolling twelve month period.
- Most incidents and assaults occurred during the rehabilitation phase, therefore there is no reason based on safety to develop a specific admission unit.
- The ID population has more incidents and assaults than the MMI population allowing for its size. Discussions should be held with the ID team on any further support required.
- The use of enhanced observation levels and additional staffing should be reviewed in light of the evidence that incidents and assaults have increased in spite of the use of these. An observation policy review should be carried out.
- The PMVA Committee should be asked to review methods of entry and exit to and from seclusion, restraint practices, SRK use and training requirements in view of the number of incidents and assaults arising in these situations.
- Further research should be carried out into the mental state of patients using the PANSS comparing those who assault with those who do not, and into a history of use of Novel Psychoactive Substances comparing those who assault with those who do not.
- Consistent spelling of names must be entered into Datix to allow accurate data analysis without manual checking and amendment.
- A summary of findings from this Report on Safety should be communicated to staff.

Mr Currie thanked Professor Thomson for this very thorough piece of work, an opened discussion on the findings within the meeting.

Mr Richards also noted the helpful nature of the work in terms of the view it provided on safety in terms of assaults and seclusions within the hospital. There was a wider scope to be considered on safety which should include the full range of indicators e.g. medication errors. There should also be room for the views of the patients.

He added that the report underlined the multi-factorial and so that a linear relationship of cause and effect would be difficult to define. He added his agreement to the need for review of observational practice to be considered within the national context.

Mrs Whitehead asked if it were possible to describe what an HDU would entail, and Professor Thomson confirmed that this would require further detailed consideration and reconfiguration of existing estate over and above the impact on staffing.

Mrs Carmichael commended the detailed use of data within the paper to increase knowledge and

help infirmed decision making. She highlighted the way in which the number of assaults is concentrated within very small number of patient, but that these incidents may have a wider cultural impact across the organisation. Mr Johnston echoed this view and asked if it was possible to draw cause and effect relationship from enhanced observation and the number of assaults. Professor Thomson offered the view that it may not be possible to establish such a relationship, but this did help flag the need for change in the delivery of care. Mr Richards added his agreement to that.

Mr Irwin underlined this point by adding that there appeared to be correlation, not causation. He emphasised that staff may feel a loss of control and feel the need for more staff support. This would be a practice development issue for the nursing team. He also offered the view that it would be important to make decisions going forward with the benefit of accurate operational information. There may be a number of models that would be operationally effective. There was discussion of perceptions on the part of some staff that an admissions unit should be considered, and that although this report may not evidence the need for that, there may be other considerations that should be taken into account to support that way forward.

Mr Crichton commended the work undertaken by Professor Thomson in conjunction with the Business Support team led by Ms Merson. He thought it important for this report to be shared with staff across the organisation and highlighted that this was one component of the wider review of the delivery of the clinical model. Members discussed the importance of engaging with staff in a meaningful way to ensure partnership working going forward.

Mr Currie added that the views of patients should also always be included. Mr Richards echoed this view adding that there was a need to shape the service in a way that would work best for the patients, and evidenced good practice, as well as best deploying resources. It would be necessary to review each of the report's recommendations.

Professor Thomson emphasised the need to move forward quickly in specific areas; the review of the use of enhanced observation levels, and that the PMVA Committee should be asked to review methods of entry and exit to and from seclusion, and restraint practices.

The Board recognised the value of the work conducted to date, and agreed that the areas highlighted should be taken forward as soon as quickly. The Board agreed that further work should be taken forward in relation to the entirety of this work and requested that a more comprehensive report be brought back to the Board for its consideration.

Action – Professor Thomson

NOTED

7 WINTER PLANNING

A paper was received from the Security Director which updated the Board on work conducted on winter planning for the current year. The Board were content to note the content and also to note that TSH had been notified by Scottish Government that there would not be an ongoing need to submit a Board approved plan. The Board agreed that in these circumstances, the winter planning cycle be remitted to the Resilience Committee and Senior Management Team for preparation, approval and review.

APPROVED

8 EDUCATIONAL SUPERVISOR - ANNUAL REPORT

A paper was received from the Medical Director which updated Members on the work carried out in TSH during the period 1 August 2017 to 31 July 2018, on undergraduate and postgraduate medical

training. This was in accordance with the General Medical Council Quality Improvement Framework for Undergraduate and Postgraduate Medical Education in the UK.

Board Members were reassured by the evidence presented of good quality teaching within TSH and were content to note the update.

NOTED

9 FOREIGN TRAVEL REQUEST

A paper was received by the Chief Executive which requested the Board's approval for eight staff members to attend the Royal College of Psychiatrists Forensic Faculty Annual Conference in Vienna in March 2019.

Members discussed the benefits to the organisation in terms of knowledge and learning within the organisation, as well as obtaining appropriate assurance that clinical cover would be in place during the course of the conference.

On this basis, the Board approved the request.

APPROVED

10 CLINICAL GOVERNANCE COMMITTEE – DRAFT MINUTES OF THE CLINICAL GOVERNANCE COMMITTEE MEETING HELD ON 9 AUGUST 2018

Mr Johnston provided an update on the key issues discussed at the Clinical Governance Committee meeting held on 9 August 2018, and the Board noted the content of these minutes.

NOTED

11 ATTENDANCE MANAGEMENT TASK GROUP – UPDATE

A report was received from the Interim Human Resources Director as requested by the Board, in view of increasing concerns regarding sickness absence levels in TSH. The Attendance Management Task Group had been set up in August 2018, and had set a corporate 3% reduction target for 31 March 2019. An Action Plan was agreed in September 2018 to support this target.

Mr Crichton outlined his role in providing enhanced leadership in this area in leading the task group as well as conducting engagement sessions with staff across the site. Increased training and support had been put into place for line managers, as well as focus on monitoring compliance with the sickness absence policy.

Mr White advised that he thought that the target of a 3% reduction in sickness absence by the end of the financial year was a realistic one. Kay Sandilands, Interim HR Director and her team were very focussed on this.

Members discussed the need for communication with staff through the line management chain to ensure that this issue was being tackled at all levels. It was hoped that the ongoing staff engagement sessions led by Mr Crichton would assist in helping staff at all levels to understand the overall impact of high levels of sickness on the organisation. The Staff Bulletin coordinated by the Head of Communications should be seen as support to face to face engagement with staff.

12 STAFF GOVERNANCE COMMITTEE

The Board was asked to note the draft minutes of the Staff Governance Committee meeting held

on 16 August 2018, and there were no points of further discussion.

NOTED

13 FINANCE REPORT AS AT 30 SEPTEMBER 2018

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

Mr McNaught led Members through the report highlighting the key areas of focus. The Board was reporting an overspend position of £0.380m to 30 September 2018, with an in-month movement of overspend at £0.025 primarily due to ongoing pressure from high levels of nursing overtime and unidentified savings being phased evenly throughout the year.

Much of the unidentified savings was based on an anticipated £0.440m share of the targeted National Boards recurring savings contribution. Mr McNaught advised that due to the current trajectory, and following discussion at the National Boards Directors of Finance meetings, only 50% of this share was agreed to be deducted from TSH RRL allocation in August. Further actions and measures were being identified to alleviate this pressure in the second half of the year, to enable the financial forecast to maintain a breakeven position for March 2019.

Mr Currie noted that there would be discussion during this meeting during the following item on the measures and actions under review, and the Board noted the content of this report.

NOTED

14 SERVICE TRANSFORMATION AND SUSTAINABILITY – UPDATE

A paper was submitted to the Board from the Director of Nursing and AHPs, which set out the progress made since the last meeting of the Board against the workstreams previously agreed in pursuit of service sustainability.

Mr Richards summarised the paper for Members, and highlighted the key points. In particular, he wished to bring Members attention to the continuing high cost of nursing overtime. In addition there had been six occasions since the start of October 2018, in which business continuity arrangements had to be put in place – inability to achieve safe staffing had meant delivery of more restrictive care including confining patients to their rooms.

Mrs Whitehead asked for reassurance around staff wellbeing, particularly with individual embers of staff working overtime hours. Mr Crichton advised that these concerns were very much to the forefront within the management team. Staff would only be asked to work more than 23 hours of overtime in any one week in exceptional circumstances, should it be the case that modifications had been made to the delivery of patient care and further staffing was still required in order to ensure safe care.

Mrs Carmichael noted the need for further reporting to include structured monitoring with timescales in place including detail on milestones in terms of progress. Mr Currie echoed this and added his concern that the Board was now headed toward the winter period in which increased sickness absence could be faced. He made a request that a further set of actions be prepared, in readiness, should more stringent planning be required during this financial year. Mr Richards confirmed that the Transformation and Sustainability Task Group would continue to give this their consideration and it was agreed that a plan would be brought to the Board at the December meeting as part of the next progress report in this regard.

Actions – Mr Richards

NOTED

15 e HEALTH – UPDATE

A report was submitted to the Board by the Director of Finance and Performance Management, which outlined changes proposed to the eHealth Workforce plan, in the context of changing technology and the significant emergence of cyber crime.

The Board noted the difficulty experienced in sourcing further capacity through other Boards and were content to note the report. It was noted that this report had been brought to the Board at their request, and that the report would be presented to the Senior Management Team for operational oversight and decision-making.

NOTED

16 BREXIT – CORPORATE RISK REGISTER UPDATE

A report was submitted to the Board from the Chief Executive, which outlined progress on local preparation for the impact of UK withdrawal from the European Union. The paper assumed that there would be agreement between the UK and EU on withdrawal and a subsequent period of transition. In this context, all meaningful preparation was being made toward operational readiness at TSH, with identification of key risks, to be logged on the Corporate Risk Register.

NOTED

17 ANNUAL REVIEW – UPDATE

A report was submitted to the Board from the Chief Executive, which outlined Scottish Government guidance issued to all Health Boards. Scottish Government had advised that TSH would have a Ministerial Review this year, and that this would take place on 14 January 2019.

In addition, the guidance to Board was to hold a public Q and A session – to encourage public engagement and accountability with the public.

Work was progressing in this regard, and a further update would be brought back to the Board at the December Meeting.

Action – Ms Smith

18 AUDIT COMMITTEE

The Board was asked to note that the Audit Committee met on 20 September 2018.

Mrs Carmichael advised that the Committee had discussed internal audit, noting that six reports had received partial assurance from the auditors. There would be follow up reports carried out in February 2019 in the hope of good progress being made against the recommendations. She urged Executive Leads to recognise the need to prioritise this work, as well as noting oversight by the Staff Governance Committee and the Staff Governance Committee.

Mr Crichton confirmed that this work was being focussed through the Risk, Finance and Performance Group.

NOTED

19 CHIEF EXECUTIVE'S REPORT

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

Mr Crichton highlighted progress to date on the Female Pathways Review, as well as visits made to TSH by colleagues from Gothenburg and the new Scottish Government Sponsor for TSH, Ms Elizabeth Connell.

Members were content to note this report.

NOTED

20 BOARD AND SUB BOARD MEETINGS – DRAFT SCHEDULE FOR 2019

Members noted and agreed a revised schedule for meetings for the Board and its standing committees during 2019.

APPROVED

21 ANY OTHER BUSINESS

Ms Merson highlighted work being progressed within the hospital on quality improvement, with an initiative being taken forward during the month of November- TSH 3030. The Board welcomed this work and confirmed that they would like to receive an update on this at the December meeting.

Action – Ms Merson

Mr Currie took this opportunity to note that this would be the final Board meeting for both Mrs Carmichael and Mr Irwin, who were retiring from their respective posts. He thanked each of them for all of their work and commitment to the Board over many years, and Members took the opportunity to thank them in the traditional way.

NOTED

22 DATE AND TIME OF NEXT MEETING

The next meeting would take place on Thursday 13 December 2018 at 9.45am in the Boardroom, The State Hospital, Carstairs.

NOTED

22 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

The meeting concluded at 12.10pm

ADOPTED BY THE BOARD

CHAIR _____
(Signed Mr Terry Currie)

DATE 25 October 2018

MINUTE ACTION POINTS
THE STATE HOSPITALS BOARD FOR SCOTLAND
(25 October 2018)

ACTION NO	AGENDA ITEM NO	ITEM	ACTION POINT	LEAD	TIMESCALE	STATUS
1	5	Chair's Report	Update on Clinical Governance Blueprint	Margaret Smith	December 2018	**On agenda – private session**
2	6	Safety Report	Further update to the Board	Lindsay Thomson	February 2019	**On agenda for February 2019**
3	14	Service Transformation and Sustainability	Planning for final quarter of 2018/19 as part of next progress report	Mark Richards	December 2018	**On agenda**

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	13 December 2018
Agenda Reference:	Item No: 6
Sponsoring Director:	Director of Nursing and AHPs
Author(s):	Person Centred Improvement Lead
Title of Report:	2018 Person Centred Improvement Service Annual Report
Purpose of Report:	For noting

1 SITUATION

As part of a refreshed approach which clearly supports the person-centred strands of TSH Board (the Board) business, the Involvement and Equality Service (IES) was re-branded in June 2018, as the 'Person Centred Improvement Service' (PCIS). This title more appropriately describes the wider function of the service, making explicit the contribution of its diverse work streams to strategic objectives within the scope of the service, namely:

- Person-centred improvement projects (Person-centred Health Care Programme (ref 1)).
- Meaningful stakeholder involvement: patients, carers, volunteers, and the public (limited to external regulatory/supporting bodies and third sector partners).
- Volunteer Services.
- Carer / Named Person / visitor support.
- Spiritual and Pastoral Care.
- Equality Agenda.
- Supporting the role of the Patients' Advocacy Service (PAS).

2 BACKGROUND

The State Hospital's Person Centred Delivery Plan builds on the national commitment to provide services developed through "mutually beneficial partnerships between patients, their families and those delivering healthcare services, which respect individual needs and values and which demonstrates compassion, continuity, clear communication and shared decision-making" (Scottish Government, 2010).

This report relates to the period January to December 2018 and reflects another productive year, during which the service continues to support wider disciplines including nursing and medical colleagues in terms of national drivers, including 'Realistic Medicine' and 'Excellence in Care' (Scottish Government, 2015), which make explicit the need to ensure that stakeholder feedback is embedded within the design of services.

This report provides an update in respect of work streams supporting Stakeholder Involvement and Engagement, Spiritual and Pastoral Care, Equality and Diversity, Carer Support and Volunteering, under the umbrella of 'person-centred care', in relation to contributing to the delivery of high quality care and treatment which is based on individual need.

This year has seen extensive partnership working with external stakeholder groups, including the Scottish Government Person Centred Stakeholder Group and deafscotland to ensure that the Board continues to discharge its duties, where appropriate, adopting a tailored approach, mindful of pressure on resources in relation to the number of patients in its care.

3 ASSESSMENT

The data illustrates progress to key performance objectives and highlights some of the challenges and development opportunities moving forward including:

- Develop and implement Supporting Patient Communication Policy, incorporating national Interpretation and Translation Policy.
- Recruitment to vacant post.
- Undertake service review to inform resourcing structure.
- Develop Hospital wide feedback processes.
- Spread skills relating to Equality Impact Assessment.
- Complete Equality Outcomes.
- Extend VIA to include staff feedback.
- Make recommendations to enhance patient / carer engagement in CPA process.
- Present outcomes emerging from Triangle of Care.
- Contribute to development of person centred KPIs informing organisational performance monitoring and reporting framework.

4 RECOMMENDATION

The Board is invited to*:*

- Note the progress outlined in the Report.
- Note the emerging issues, learning opportunities and key actions for the next twelve months.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives?	Supports delivery of Person-centred service delivery objectives within TSH Local Delivery Plan.
Workforce Implications	None
Financial Implications	None
Route to the Committee *Which groups were involved in contributing to the paper and recommendations?*	Person Centred Improvement Steering Group Patient Partnership Group Carers' Support Group Volunteer Service Group Scottish Health Council
Risk Assessment *(Outline any significant risks and associated mitigation)*	No significant risks identified
Assessment of Impact on Stakeholder Experience	Captures feedback relating to stakeholder experience and provides opportunities to develop systems / processes through which learning from feedback informs service design. Supports Board's commitment to assessing the impact of service delivery on stakeholder experience.
Equality Impact Assessment	N/A

THE STATE HOSPITALS BOARD FOR SCOTLAND

PERSON CENTRED IMPROVEMENT SERVICE
(known as INVOLVEMENT AND EQUALITY SERVICE until June 2018)

ANNUAL REPORT

JANUARY - DECEMBER 2018

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1. Introduction

Since The State Hospital (TSH Involvement and Equality Strategy was developed in 2014, as an extension of the original national Patient Focus Public Involvement (PFPI) drivers, the organisation has seen the continued evolvement of the person-centred agenda, supporting a quality improvement (QI) approach.

As part of a refreshed approach which clearly supports the person-centred strands of TSH Board (the Board) business, the Involvement and Equality Service (IES) was re-branded in June 2018, as the 'Person Centred Improvement Service' (PCIS). This title more appropriately describes the wider function of the service, making explicit the contribution of its diverse work streams to strategic objectives within the scope of the service, namely:

- Person-centred improvement projects (Person-centred Health Care Programme (ref 1)).
- Meaningful stakeholder involvement: patients, carers, volunteers, and the public (limited to external regulatory/supporting bodies and third sector partners).
- Volunteer Services.
- Carer / Named Person / visitor support.
- Spiritual and Pastoral Care.
- Equality Agenda.
- Supporting the role of the Patients' Advocacy Service (PAS).

The State Hospital's Person Centred Delivery Plan (appendix 1) builds on the national commitment to provide services developed through "mutually beneficial partnerships between patients, their families and those delivering healthcare services, which respect individual needs and values and which demonstrates compassion, continuity, clear communication and shared decision-making" (Scottish Government, 2010 (ref 2)).

This report relates to the period January to December 2018 (due to the timing of submission of this report, data relates to the period 1/12/17-30/11/18) and reflects another productive year, during which the service continues to support wider disciplines including nursing and medical colleagues in terms of national drivers, including 'Realistic Medicine' (Scottish Government, 2016) (ref 3) and 'Excellence in Care' (Scottish Government, 2015) (ref 4), which make explicit the need to ensure that stakeholder feedback is embedded within the design of services.

The Board is committed to continuously improving systems and processes which support safe, effective, person-centred care, adopting a balanced and proportionate response to legislative and national drivers including:

- Mental Health Strategy (2017-2027) (ref 5).
- Health and Social Care Delivery Plan (2016) (ref 6).
- Rights in Mind (2017) (ref 7)).
- Safety and Protection of Patients, Staff and Volunteers in NHSScotland (2017) (ref 8).
- Public Sector Equality Duty (2016) (ref 9).
- British Sign Language (BSL) National Plan (2017-2023) (ref 10).
- Equality Act (2010) (Specific Duties) (Scotland) (ref 11).
- Patient Rights (Scotland) Act (2011) (ref 12).
- Carers (Scotland) Act (2016) (ref 13).
- Fairer Scotland Duty (2018) (ref 14).

This year has seen extensive partnership working with external stakeholder groups, including the Scottish Government Person Centred Stakeholder Group and deafscotland to ensure that the Board continues to discharge its duties, where appropriate, adopting a tailored approach, mindful of pressure on resources in relation to the number of patients in its care.

2. Governance arrangements

The Person Centred Improvement Steering Group (PCISG), chaired by the Director of Nursing and Allied Health Professions, meet monthly to monitor progress in respect of the mainstreaming of processes supporting delivery of the above remit. This multi-disciplinary group ensures the organisation is compliant with legislative requirements and supports the service to respond to national drivers and local practice relating to the above portfolio. The patient Chair of the Patient Partnership Group (PPG), a member of the Carers' Forum and Volunteer Service Group are included within the core membership, in addition to a representative from the Scottish Health Council and the Patient Advocacy Service (PAS).

The group discuss a wide range of quarterly monitoring reports including:

- Patient and Visitor Experience.
- Volunteering input.
- Spiritual and Pastoral Care input.
- Equality Outcomes objectives.
- Advocacy input.
- Health equalities.
- Learning from Complaints and Feedback.
- Person Centred Improvement Projects.

In recognition of the value of maximising opportunities to embed patient and carer experience in service design, the 'Learning from Feedback' Report is also included within quarterly monitoring reports presented to the Senior Management Team, Clinical Governance Group (CGG) and Clinical Governance Committee.

3. Key pieces of work undertaken

- Delivered person-centred 'What Matters to You?' (WMTY) initiative (appendix 2).
- Developed TSH BSL Action Plan.
- Developed new Visitor Welcome Pack.
- Developed new Volunteer Welcome Pack.
- Developed new structured spiritual and pastoral care handover tool.
- Developed Volunteer Impact Assessment Tool.
- Developed Accessible Information version of TSH Clinical Model to support patient engagement in the consultation process
- Undertook baseline assessment of new Triangle of Care (ToC) tool (ref 1.
- Supported PPG to contribute to development of individually tailored healthy living plans and Physical Activity Workbook.

4. Wider input

TSH Strategic Objectives 2017-22: Quality Ambition No. 9: Effective
"Create conditions for supporting quality assurance, quality improvement and change".

Since completing the Scottish Improvement Leadership Programme in 2015, the Person Centred Improvement Lead (PCIL) has been awarded a Post-graduate Certificate in Quality Improvement. This further development of QI knowledge and skills has been invaluable in terms of contributing to the strategic commitment to the spread of skills in this area. The PCIL regularly provides coaching and mentoring input across the Hospital, directly relating to improvement initiatives including:

- WMTY outcomes.
- Patient safety e.g. Improved Observations of Care, Patient Safety Climate Tool.
- Patient Active Day project.
- TSH 3030 initiative.
- Patient Meal Service project.
- Equality of access e.g. Intellectual Disability/non-English speaking patients.
- Carer engagement in the Care Programme Approach (CPA) process.

These transferable skills are also used to support external QI projects including:

- Investing in Volunteering Award Best Practice.

- Assessing the impact of volunteering.
- Refreshed Spiritual and Pastoral Care standards.
- NHS Interpretation and Translation Processes.
- National Health and Social Care Equality Impact Assessment

As a member of a number of internal groups, the PCIL ensures the views of stakeholders are shared within discussions informing service design:

- Senior Management Team (SMT).
- Clinical Governance Group.
- Service Sustainability and Transformation Group.
- Skye Centre Leadership Team.
- Patient Active Day Project Group.
- Mental Health Practice Steering Group.
- Clinical Forum.
- QI Forum.
- Senior management recruitment stakeholder forums.
- Service change consultation forums.

The PCIL also ensures the unique needs of TSH stakeholders are shared in respect of influencing the national person-centred landscape, through membership of external groups including:

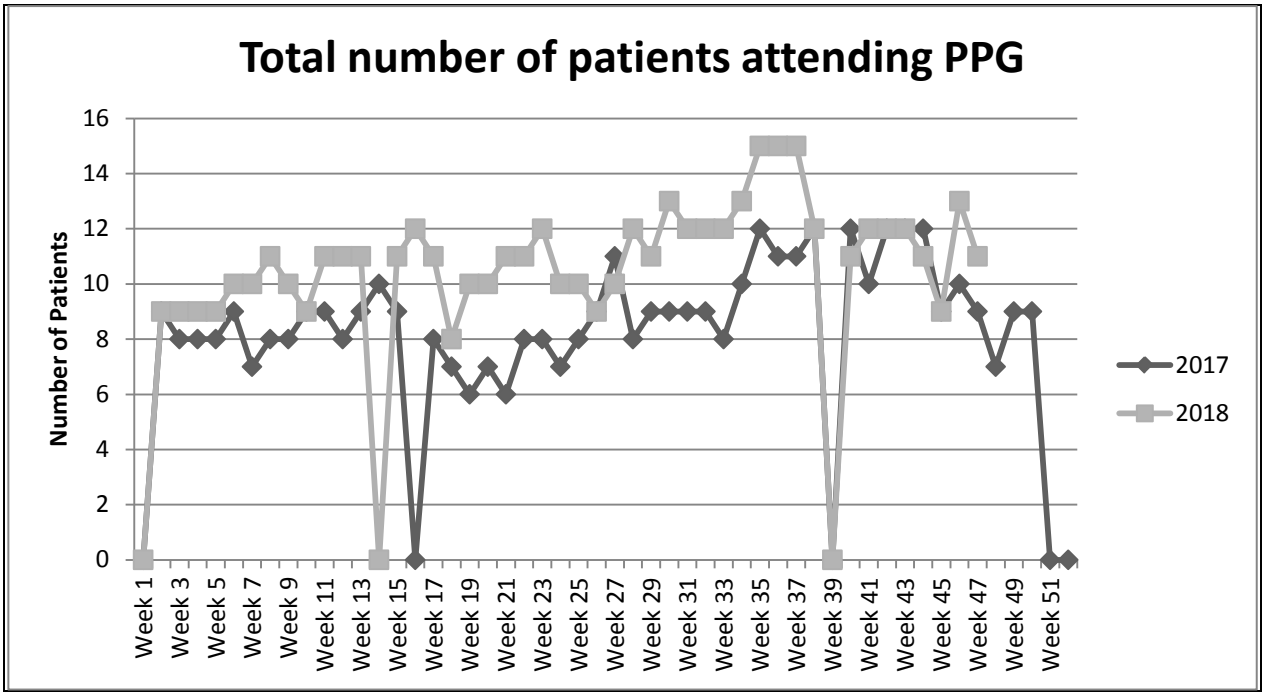
- NHS Person-centred Leads.
- NHS Equality Leads.
- Scottish Government Person Centred Stakeholder Forum.
- NHS/Third Sector Volunteer Leads.
- Scottish Government Cross-Party Volunteering Forum.
- NHS Spiritual and Pastoral Care Leads.
- Investing in Volunteers.

In recognition of providing external QI input, the PCIL was invited to join the International Forum: 2019 Quality & Safety in Healthcare organising committee, through which TSH has been selected to host one of the conference experience sessions in March, 2019. As a result of this input, TSH has been offered 5 fully funded delegate places for the three day conference in Glasgow.

5. Key performance indicators

	Improvement Indicator	Outcome Measures
1.	Patients from all areas of the Hospital are meaningfully engaged in contributing to service design.	a) Patient Partnership Group (PPG) is facilitated 48 weeks during the year. b) PPG membership includes representation from all hubs. c) An average of 10 patients attend PPG each week.
2.	More patients have the opportunity to receive visits.	a) 50% increase in volunteer visitor referrals when compared to 2017. b) Conversion rate of 60% (from referral to visits commencing).
3.	Evidence impact of volunteering programme.	a) Undertake baseline assessment using locally tailored Volunteer Impact Assessment. b) 'Green' level achieved for 80% of indicators.
4.	Effective Spiritual and Pastoral Care handover on transfer to step down services.	a) Handover reports included within transfer documentation for 100% of patients transferring to step-down services, who have requested continuity of access to spiritual and pastoral care activities.
5.	Carers are enabled to contribute meaningfully to patient outcomes.	a) Undertake baseline ToC assessment. b) 'Green' level achieved for 60% of indicators.
6.	Quality of Equality Impact Assessments undertaken	a) 25% increase in quality compliance scores when compared to 2017.
7.	Progress to achieving the three TSH Equality Outcomes by April 2020.	a) Two outcomes fully completed.

1. Patients from all areas of the Hospital are meaningfully engaged in contributing to service design



a) ***Patient Partnership Group (PPG) facilitated 48 weeks during the year***

Delivery to outcome measure a): Achieved. Target of less than 52 weeks accounts for 4 weeks public holidays. Significant challenges around resourcing, with support from other disciplines on five occasions and direct input from PCIL on a regular basis to ensure continuity of service delivery.

b) ***PPG membership includes representation from all 4 hubs***

Delivery to outcome measure b): Achieved. 100% of hubs represented at all meetings, succession plan in place to ensure continuity of involvement as patients transfer to step down services.

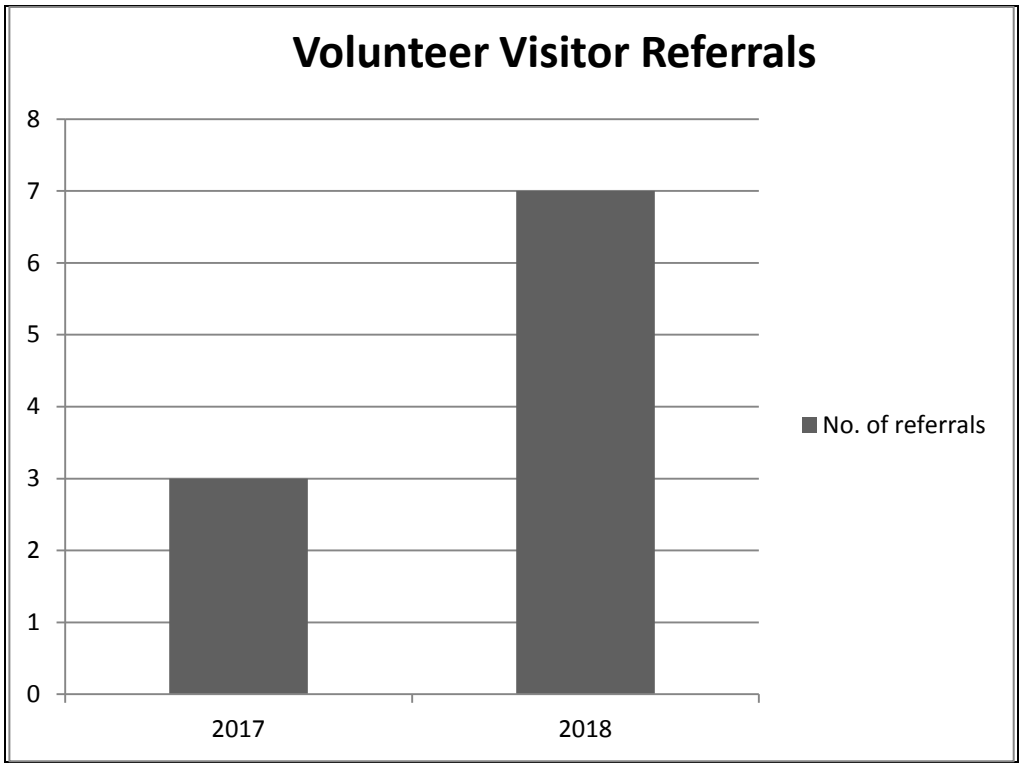
c) *An average of 10 patients attend PPG each week*

Delivery to outcome measure c): Achieved. Target of ten patients influenced by total number of people in the group, including staff and visitors in conjunction with environmental Health and Safety restrictions, safety and security when working with large patient groups and ensuring all patients have the opportunity to engage meaningfully. Attendance at meetings fluctuates depending on the meeting agenda, mental health presentation of group members and requirement to attend tribunals and external clinical appointments which cannot be scheduled around the group timetable. The average attendance in 2017 was 9 patients, increasing to 12 this year.

"Being PPG chair has made me more confident and helped me to cope with meeting new people. Patients ask for my help. People listen to what I'm saying. I go to meetings with Hospital Managers and went to the Advocacy AGM and got to speak to the Health Minister from the government when they were in talking to patients, carers and volunteers. It's been a great experience.

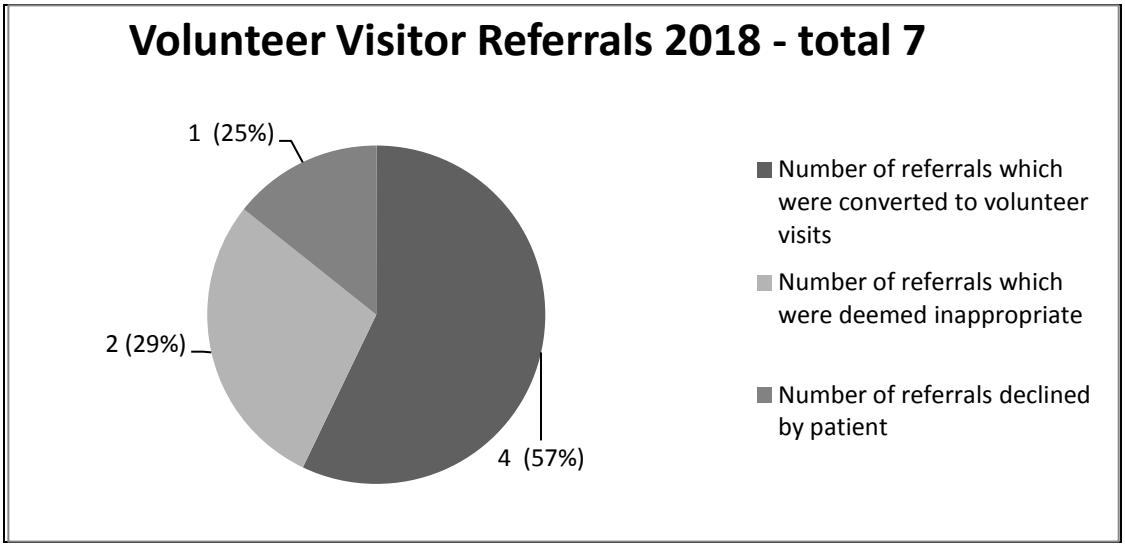
Outgoing PPG Chair, November 2018

2. More patients have the opportunity to receive visits



a) 50% increase in volunteer visitor referrals when compared to 2017

Delivery to outcome measure a): Achieved. Hub Leadership Teams have responded to data shared via the Clinical Outcomes Monitoring Reports, adopting a more proactive approach to encouraging patients who receive no visits to be referred for this service. Due to the increased level of referrals, an additional 4 volunteer visitors were recruited during this year.



b) Conversion rate of 60% (from referral to visits commencing)

Delivery to outcome measure b): Four of the seven patients referred are now receiving visits, equating to a 57% conversion rate against the target of 60%. One of the patients involved experienced a significant decline in metal health during the process and was therefore unable to engage at that point. The referral is reviewed regularly by the Clinical Team who will resubmit when appropriate. Two referrals received from patients within the 'hard to reach' category were deemed inappropriate following the screening process.

"I've been in here for years and never had a visitor before because my family and friends don't want anything to do with me. I look forward to when the volunteer visits because we talk about things that I used to do and I get to hear about what's going on outside. The volunteer tells me lots of stories which are funny. I laugh a lot and so does the volunteer".

TSH patient October, 2018

"I'm very fortunate to be visiting someone who shares my interests in art and I really appreciate the interactions we share. I feel that I can bring a little bit of what is happening 'outside' into our conversations and maybe help expand his horizons. I also feel that I learn about the life he has in the hospital and the support he willingly receives. He is extremely hospitable and cares for my needs during the visits, which is very much appreciated by me".

TSH Volunteer Visitors November, 2018

"In my short time as a volunteer visitor what I have come to realise is that, although my view is that our conversations are quite mundane and random, they are very meaningful for the patient. That makes it very worthwhile for me, knowing that just my turning up and giving him my attention for even a short time is very much appreciated".

3. Evidence impact of volunteering programme

a) Undertake baseline assessment using locally tailored Volunteer Impact Assessment (VIA)

Delivery to outcome measure a): Challenges in relation to resourcing within the service delayed commencement of this piece of work. Development of TSH VIA was completed in November, 2018, following extensive engagement with stakeholders. The PCISG are scheduled to discuss process and implementation in December, 2018 with a view to undertaking the initial baseline assessment in January 2019, from which outcomes will inform development of this KPI for 2019.

b) Green' level achieved for 80% of indicators

Delivery to outcome measure b): See above.

4. Effective Spiritual and Pastoral Care handover on transfer to step down services

a) Handover reports included within transfer documentation for 100% of patients transferring to step-down services, who have requested continuity of access to spiritual and pastoral care activities.

Delivery to outcome measure a): Process has been agreed to include Spiritual and Pastoral Care handover information within Occupational Therapy (OT) discharge/transfer handover reports, given the symbiotic relationship between core OT values principles and the OT model of practice. A pro-forma has been developed in conjunction with patients and the chaplaincy team however, no patients engaged in spiritual and pastoral care activities have transferred from TSH during this reporting period.

5. Carers are enabled to contribute meaningfully to patient outcomes

a) Undertake baseline ToC assessment

Delivery to outcome measure a): This national tool has been adapted in conjunction with stakeholders for use within TSH. The draft tool was approved for implementation by CGG in July 2018. The initial baseline assessment commenced in September, 2018. Outcomes will inform development of this KPI for 2019.

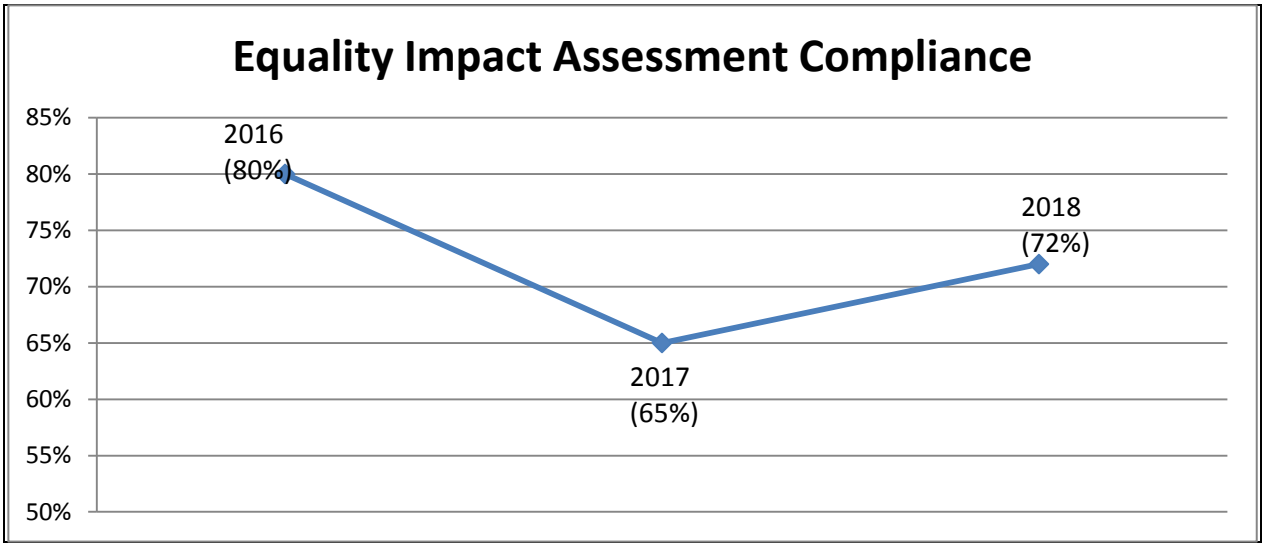
b) 'Green' level achieved for 60% of indicators

Delivery to outcome measure b): See above.

6. Quality of Equality Impact Assessments Undertaken

a) 25% increase in quality compliance scores when compared to 2017

Delivery to outcome measure a): Although quality compliance has increased by 12% since 2017, TSH there is still work to be done to enhance the quality of Equality Impact Assessments (EQIA) undertaken.



The data indicates a lack of awareness around the impact of policies /protocols in relation to the Protected Characteristic groups**.** The characteristics relating to 'disability', 'age' and 'race' are of significant relevance to the organisation in the context of future-proofing clinical service delivery, particularly relevant to current discussions relating to the configuration of services moving forward.

TSH EQIA pro-forma has been updated this year to incorporate the Board's duty to assess the socio-economic impact of service delivery.

Local expertise supporting the EQIA process is an area for consideration as the PCIL is currently responsible for providing support, in addition to screening all completed EQIAs prior to submission to SMT. Due to resourcing issues within the service it has not been possible to spread this skill set within the team to support wider spread across all services.

There is an appetite to develop an electronic national EQIA tool which could be tailored for use locally. The NHS Equality Leads are in the very early stages of exploring this option which would have financial implications for the Board in relation to set-up costs and ongoing upgrades.

7. Progress to achieving the three TSH Equality Outcomes by April 2020

a) ***Two outcomes fully completed***

Delivery to outcome measure a):

- Outcome 1 - The needs of vulnerable patients with a mental health diagnosis are protected by embedding implementation of section 22 of the Mental Health (Scotland) Act, 2015: ***Complete.***
- Outcome 2 - Implementation of individually tailored healthy lifestyle plans which support the physical health and well being of all patients within the Hospital: ***8 of 13 actions complete.***
- Outcome 3 - Service delivery will enable all patients within the Hospital to benefit from equitable access to care and treatment: ***6 of 14 actions complete.***

6. Wider service specific performance objectives

Delivery of Mandatory Equality and Diversity Training

This area of our training suite continues to be delivered via the mandatory online module, in addition to attendance at a half day interactive workshop. In common with other mandatory training, we continue to experience challenges, in terms of nursing attendance, particularly valuable in terms of the opportunity to engage in multi-disciplinary values based discussions, based on local case studies. With limited opportunity to release nursing staff, members of this key profession are disadvantaged in terms of engaging in this element of equality and diversity training – nursing equates to 75% of the total of all staff still to attend the workshop (a decrease of 14% since last year's report). In mitigation, 97% of all staff have completed the

online module, which demonstrates a commitment to ensuring staff are aware of their responsibilities within the legislative framework.

2017 Patient Experience Questionnaire: Respondent Data

- 57% (68%) response rate, equating to 63 (77) patients of 111 (113) in the Hospital at that time.
- 48 (66) (76% (86%)) report that services meet their individual needs.
- 40 (64% (82%)) feel they are treated with respect.
- *51 (81%) indicated that staff involve them in their care planning.
- *51, (81%) are of the view that staff listen to any concerns they may have.
- * 50 (80% feel staff act on their concerns.

The primary theme emerging from narrative shared relates to a reduction in opportunities to engage in activity within the wards / hubs and Skye Centre.

Figures in brackets represent 2016 data. *New question this year.

Consistently reduced completion rates informed a key action for this year to review, update and implement refreshed feedback exercises, including the annual experience questionnaire. This piece of work remains outstanding as a result of ongoing resourcing issues within the service. However, the Board should be reassured that activity in this respect relating to discrete areas including the WMTY initiative, the Clinical Model consultation, Improved Observations Practice project, catering and cleanliness and the CPA process have been prioritised this year. The PCIL is currently developing a TSH stakeholder feedback protocol to support a more robust approach to eliciting feedback from patients in response to what our 'customers' are telling us about 'feedback fatigue'. SMT will be asked to agree on a three year engagement plan, through which the Board will seek feedback which is required for national benchmarking purposes / to inform development of clinical services and which demonstrates how patient feedback has been used to design services. As a result of this broad approach, the 2018 Patient Experience Questionnaire will not be facilitated in its original format.

Patient Engagement in Spiritual and Pastoral Care Activities

This year has since a 4% increase in the number of patients regularly engaged in spiritual and pastoral care activities, including weekly denominational services of worship, Christian Fellowship and 1:1 ward based input. This increase can be attributed to additional ward based input, enabling the 'hard to reach' patient group to benefit from this element of care and treatment.

The church service and Christian Fellowship was cancelled once this year, impacting on 15 patients, due to weather related risks in terms of patient access to the Skye Centre. As a result of resourcing challenges, the service of Mass was cancelled on two occasions, impacting on 10 patients each week.

2017 Visit Experience Questionnaire

32 questionnaires were returned, representing a decrease of 10 from 2016.

Caution should therefore be applied to the data emerging from this feedback initiative in terms of being representative of the wider visitor group. Given that most respondents attend CPA Meetings, it is likely that we are hearing about the experience of this small group of carers.

The majority of respondents:

- Visit once a month.
- Prefer to be contacted via the post.
- Feel they are treated with respect.
- Feel safe when they visit.
- Are involved in decisions about care and treatment.
- Attend CPA Meetings.
- Feel able to share any concerns about their own / patient experience.

Narrative includes a number of positive compliments about staff. There are also comments about the value of social events and frustrations relating to restrictions placed on visitor gifts of food and fluids as part of the Supporting Healthy Choices work streams.

The number of respondents has reduced again this year, despite considerable resources invested in securing an increase in completion rates by promoting the questionnaire via the Carers' Reception outreach service and Carers' Newsletter, electronic carers' forum and posting the form to those who have consented to receiving such information. Undoubtedly there has been an impact on engagement as result of GDPR. The PCIS is working closely with the visitor database owner to ensure access is enabled, where appropriate to visitor details. There have been delays with this piece of work due to the need for the database to be updated prior to being shared. As with the Patient Experience Questionnaire, consideration needs to be given to the content of future engagement exercises, which should elicit information enabling local teams to enhance the visitor experience. Given the delay in accessing the updated database and ongoing Triangle of Care baseline assessment, the 2018 Visit Experience Questionnaire will not be facilitated.

Initial work on completing the ToC has highlighted some challenges in relation to understanding the impact of service delivery on people who have contact with patients, as a result of the number of descriptors in use, confirmed via those responding to the 2017 questionnaire:

1. Would you describe yourself as:	
Carer	47% (15)
Visitor	31% (10)
Named person	44% (14)
Relative	69% (22)
Friend	16% (5)

As part of the ToC, a local definition is being developed to more effectively describe the role of each group in relation to how the organisation engages with these groups who provide valuable support to our patients.

Volunteering Service Development

There are currently 20 volunteers (23 in 2017) providing a wide range of input to complement service delivery across the Hospital. With Interest Checklists now in place for all patients, work will commence in 2019 on the development of tailored volunteer roles to support activity within the ward environment. We are working closely with Volunteer Scotland, through whom current vacancies are advertised for volunteers with specific skills to enhance the range of specialist activities available e.g. learning to play a musical instrument. This project will be extended to include a needs analysis, which supports Clinical Teams to achieve wider care and treatment objectives, e.g. developing communication skills, engaging in activities which equip patients with coping mechanisms in response to deteriorating in mental health. Partnership working with Occupational Therapists will be fundamental to this wider approach to volunteering.

Patient Advocacy Service (PAS)

The PCIS continue to support the role of PAS, ensuring that the PAS Patient Board member is able to attend regular meetings and participate fully in the PAS AGM, held externally, via video link, along with the PPG Chair.

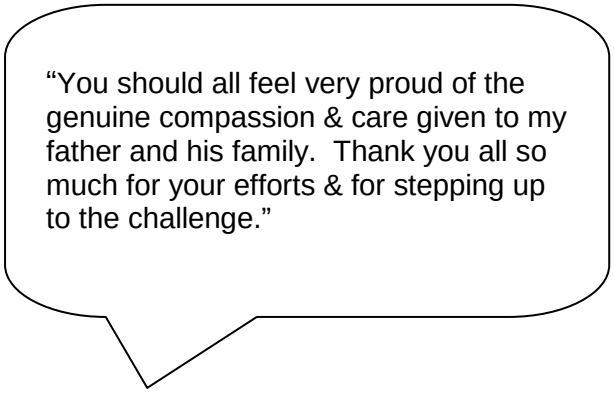
The PCIL meets regularly with the PAS Manager to discuss forthcoming Mental Welfare Commission visits, sharing feedback to maximise opportunities for learning.

Work has commenced on the Advocacy Service tendering process, due to culminate in May 2018, at which point the successful bidder will be appointed.

7. Contribution to organisational objectives

In addition to working towards service KPIs and objectives, the PCIS has been proactive in terms of supporting progress to a number of organisational objectives within the Local Delivery Plan 2017-2020:

Clinical Model Principle 2 Patient Focussed Care	**Action**	**Outputs**
Local Delivery Plan 7.2 Patient Experience "As outlined in the National Services Framework, we will place patients and their carers at the centre of all service planning and delivery".	Meaningfully engage patients and carers in the Supporting Healthy Choices (SHC) project implementation work streams.	Monthly SHC sub-group of PPG attended by SHC Project Lead contributing to development of: • individually tailored healthy living plans; • processes to enhance shopping opportunities for non food items.
	Respond to anecdotal feedback from patients and carers in respect of challenges around meaningfully contributing to the Care Programme Approach (CPA) process including: • time of meeting; • duration of meeting; • complex paperwork; • numbers present; • language (jargon); • support to contribute to the process.	Semi-structured feedback tool now in use to elicit data relating to attendance at discharge/transfer CPA Meetings. Insufficient data available at this point to identify themes. Feedback pro-forma developed for use as part of the Annual CPA review process.
	Respond to patient and carer feedback relating to challenges around the clinical model of service delivery, specifically in respect of access to activity and being confined to bedrooms periodically as part of the organisational response to resourcing challenges.	Easy Read version of TSH Clinical Model principles developed to enable PPG to engage meaningfully in this consultation. Director of Nursing and AHP and Clinical Operations Manager made aware through direct feedback from PPG Chair within PCISG. Feedback shared through quarterly 'Learning from Feedback' Report. Feedback incorporated within wider piece of work commissioned by the Board in relation to reviewing Clinical Service Delivery Model.
	Support patients to engage in the national 'WMTY?' initiative (June 2018).	Dedicated Skye Centre stakeholder event involving patients, staff and volunteers, from which action plans have been developed from feedback shared. Quarterly progress updates reviewed by teams involved informing service development. All hubs participated, developing action plans which are monitored by Hub Leadership Teams. Quarterly update reporting to PCISG, Clinical Governance Committee and SMT WMTY initiative outputs shared nationally as an exemplar of 'best practice' by Health Improvement Scotland via the Person-centred Health and Care Programme.

	Enable patient involvement within values based recruitment practice to ensure the patient 'voice' is included within TSH recruitment practice at all levels.	This year the PCIL has acted as a conduit for the patient group, participating within the stakeholder panels as part of the recruitment process for Chief Executive, Security Director and Senior Charge Nurse posts.
Ensure the patient and carer 'voice' is heard at a senior level within the organisation.  This carer wanted to pass on her thanks to all the staff involved in her father's care while he was at the Hospital and said she could not praise the professionalism and personal care highly enough.		Leadership walk rounds continue, facilitated by senior managers, during which time patients are invited to share their experience. Throughout this year, TSH Board Meetings have regularly commenced with a patient / carer story, shared through a range of medium including Emotional Touchpoints, the River Model and WMTY creative feedback outputs. In addition to disseminating specific carer feedback with Clinical Teams, this data is shared with the Executive Team and SMT. The quote shared recognises the challenges of caring for terminally ill patients within this environment. A truly person-centred approach is adopted to ensure that patients at the end stages of life can remain with their peers and staff who know them well, in an environment which is familiar to them. This positive feedback is particularly important for staff who are balancing the needs of a complex patient group within an environment where this type of tailored approach is required.
	Engage with external partner stakeholders to ensure the unique needs of TSH patients / carers are understood and opportunities to influence national service / policy design are maximised.	The Scottish Health Council attends PPG regularly and form part of the membership of the PCISG. The PCIL meets with the Mental Welfare Commission (MWC) as part of their regular visit process. Contact throughout the year is ongoing in response to patient feedback shared directly with the MWC. The Person-centred Health Improvement Scotland Team has attended PPG this year and provide feedback in response to national submissions relating to the WMTY initiative. The Scottish Government (SG) Person-centred Lead has attended PPG this year and engages with the PCIL through the quarterly SG Person-centred Stakeholder Group meetings. The PCIL is a member of the organising committee for the 2019 Quality & Safety in Healthcare Conference. The TSH will facilitate an 'experience' session locally for 20 delegates in March, 2019. PPG will be involved in this event, sharing their experience and learning about forensic services in other countries.

8. Progress to key actions identified within 2017 annual report

Action	Outcome	Further Developments
Develop and implement volunteering impact assessment.	Assessment tool developed. Baseline assessment scheduled for January 2019.	Analyse outcomes to identify opportunities for learning. Extend tool to incorporate staff feedback.
Develop Spiritual and Pastoral Care Handover Tool.	Complete.	Monitor through ongoing networking with step down services.
Refreshed Involvement and Equality Strategy.	Superseded by development and implementation of Person Centred Improvement Service Delivery Plan.	Review against national drivers and local Service Strategy in 2021.
Recruitment to vacant post.	Temporary part-time use of pool staff has continued throughout this year.	Undertake review of roles and seek approval for resourcing to staffing establishment.
Implement CPA Review Meeting patient / carer feedback tools.	Complete.	Analyse outcomes to identify opportunities for learning.
Review, update and implement refreshed patient / carer/ visitor/ Named Person experience feedback mechanisms.	Not yet commenced due to resourcing challenges.	
Implement ToC Tool	Complete. Baseline assessment commenced September 2018.	Analyse outcomes to identify opportunities for learning.
Develop 2018-2021 Volunteering Improvement Plan.	This national tool no longer in use. Superseded by development of local VIA.	Analyse outcomes to identify opportunities for learning.
Develop and implement Supporting Patient Communication Policy	Ongoing. Delay due to resourcing challenges within the service, in addition to the need to develop and publish local BSL Action Plan (not part of original objectives) which was achieved within timeframe.	

9. Challenges, Solutions and Development Opportunities

Challenges	Solutions / Development Opportunities
Learning from Feedback Time consuming data entry to a limited reporting system, as part of the national Datix complaints reporting process. This results in having to make feedback from TSH patients fit within categories, which have been developed nationally and are limited in scope and, in some cases, relevance to this setting. Issues relating to some duplication in data collection and gaps in sharing feedback across relevant services.	Review of complaints function completed October, 2018 by Head of Corporate Planning and business Support. Report to SMT November 2018 includes recommendations relating to: • Clarity of Complaints Manager role. • Need to more robustly triangulate intelligence gathered from feedback shared with PAS, PCIS and Complaints Officer. • Development of tailored feedback data collection system which supports national Person Centred initiatives e.g. 'Excellence in Care', 'Realistic Medicine', incorporating the 'Five Must Do's' and 'WMTY' themes.
Hospital Wide Patient Feedback Processes • Inconsistent approach to eliciting patient feedback, in addition to a lack of planning. This has led to 'feedback fatigue' and issues in relation to an inclusive approach, which demonstrates that all patients are enabled to share their views, using their preferred form of communication. • Feedback collected could be better aligned to supporting development of clinical services in terms of questions posed. • Gaps in the wider sharing of learning emerging from feedback.	• Develop Supporting Patient Communication Policy. • Develop guidance to support a consistent Hospital wide approach to eliciting and sharing patient feedback, including outputs emerging which provide opportunities for sharing best practice. • Develop feedback process which enables the organisation to benchmark against national drivers, in addition to supporting local quality assurance work which. • Introduce robust reporting process to enable Leadership Teams to respond to feedback directly relating to their area.
Equality Impact Assessments Spread the knowledge and skills relating to this process to ensure that the organisation adopts a resilient approach and is able to demonstrate a consistent, robust approach which satisfies scrutiny in relation to equality of service delivery to *Protected Characteristic groups: *Age, disability, gender, gender reassignment, marriage and civil partnership, maternity and pregnancy, race/ethnicity, religion and/or belief, sexual orientation.	• Work with Service Leads to develop expertise within their areas, including delivery of supplementary training. • Contribute to national work streams informing development of a streamlined NHS electronic process which supports the sharing of feedback from protected characteristic stakeholder groups.

10. Implications

Staffing

Despite significant progress again this year, the increased workload in relation to supporting a more robust quality improvement approach has had some implications in terms of completing the full complement of key actions.

The Patient Involvement Facilitator (PIF) role has been vacant since December 2015. This gap in clinical staffing impacted significantly on facilitation of front line groups and the ward outreach programme, specifically around spiritual and pastoral care and the patient involvement agenda. Since 2016, the service has been fortunate to benefit from the input of an experienced staff nurse registered with the Nursing Pool, who has consistently provided two/three full days input. This PIF post has a full-time remit within the

establishment of this area of service delivery. This contingency part-time resourcing is insufficient in terms of meeting the service objectives relating to follow-up work streams supporting improvement of the patient / carer / volunteer experience.

Maintaining facilitation of front line groups has, on many occasions, this year relied on support from a wide range of colleagues across the Hospital. Given the wider resourcing challenges, this has, on occasion, been problematic, leading to the cancellation of spiritual and pastoral care input on five occasions.

The PCIS regularly support the work of the Skye Centre Team to ensure placements remain open. Data is now being recorded due to the level of input which is undoubtedly impacting on progress to service objectives:

- September – 34.5 hours
- October – 22.5 hours
- November – 2 hours

A recruitment initiation process was undertaken in November 2017 to recruit to the vacant PIF post, as part of establishment. In addition to contributing to the significant savings required to meet the Board's target, the decision was taken to await the outcome of the recent review of the Complaints function prior to making any decision in this respect.

Having agreed the Person Centred Improvement Delivery Plan this year and with resourcing issues remaining static, a service review will be undertaken early in 2019 with a view to ensuring staffing is appropriate in terms of achieving agreed objectives. Consideration will also be given to the wider input provided in terms of business support across the organisation, which may not be fully reflected within the delivery plan.

Finance

All elements of the service were delivered within budget during the 2017/18 financial year. As a result of the resourcing shortfall, significant savings have been made within the workforce element of the PCIS budget, contributing to the wider shortfalls within the Nursing and AHP directorate.

11. Key actions for the next twelve months

- *Develop and implement Supporting Patient Communication Policy, incorporating national Interpretation and Translation Policy.
- *Recruitment to vacant post.
- Undertake service review to inform resourcing structure.
- Develop Hospital wide feedback processes.
- Facilitate WMTY initiative.
- Facilitate TSH Annual Review Stakeholder forum.
- Spread skills relating to EQIA.
- Complete Equality Outcomes.
- Extend VIA to include staff feedback.
- Make recommendations to enhance patient / carer engagement in CPA process.
- Present outcomes emerging from ToC.
- Contribute to the spread of QI skills Hospital wide as QI coach / mentor.
- Contribute to development of person centred KPIs informing organisational performance monitoring and reporting framework.

** Carried forward from 2018.*

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Appendix 1

The State Hospital

Person Centred Improvement Service Delivery Plan 2018-21

June 2018

Introduction

This delivery plan builds on The State Hospital's (TSH) Board (the Board) commitment to *deliver services developed through "mutually beneficial partnerships between patients, their families and those delivering healthcare services, which respect individual needs and values and which demonstrates compassion, continuity, clear communication and shared decision-making"* *(The Healthcare Quality Strategy for NHSScotland (Scottish Government, 2010).*

Since the Involvement and Equality Strategy was developed in 2014, as an extension of the original national Patient Focus Public Involvement (PFPI) drivers, the organisation has seen the continued evolvement of the person-centred agenda, supporting a quality improvement (QI) approach to areas within the scope of the service:

- Stakeholder involvement: patients, carers, volunteers, and the public (limited to external regulatory/supporting bodies and third sector partners);
- Supporting the role of the Patients' Advocacy Service (PAS);
- Volunteer Services;
- Carer / Named Person / visitor support;
- Spiritual and Pastoral Care;
- Equality Agenda;
- Person-centred improvement projects.

As part of a refreshed approach which clearly supports the person-centred strands of the Board's business, it is proposed that the Involvement and Equality Service (IES) is re-branded, As the 'Person-centred Improvement Team' (PcIT). This title more appropriately describes the wider function of the service, making explicit the contribution of its diverse work streams to strategic objectives.

Purpose

The person-centred landscape continues to evolve, informed, since the 2014 Involvement and Equality Strategy was published by new / refreshed legislation and drivers including:

- Our Voice: working together to improve health and social care (Scottish Health Council, 2015);
- 'What Matters to You?' (Health Improvement Scotland, 2015)
- Participation Standards (Complaints and Feedback) (Scottish Government, 2016);
- Carers (Scotland) Act (Scottish Government, 2016);
- Health and Social Care Delivery Plan (Scottish Government, 2016);
- Part 4 Health (Tobacco, Nicotine Etc. and Care) (Scotland) Act (Scottish Government, 2016)
- Mental Health Strategy: 2017-2027 (Scottish Government, 2017);
- Rights in Mind (Mental Welfare Commission, 2017);
- NHS Model Complaints Handling Procedure (MCHP) (Scottish Government, 2017);
- Safety and Protection of Patients, Staff and Volunteers in NHSScotland (Scottish Government, DL (2017);
- British Sign Language (BSL) National Plan 2017-2023 (Scottish Government, 2017);
- Fairer Scotland Duty (Scottish Government, 2018);
- 2020 Vision for Health and Social Care (Scottish Government).

In addition to supporting the organisation to demonstrate a robust response to the above, this delivery plan contributes to achievement of local strategic drivers, initiatives and national data submissions including:

- Service Strategy (2017-2020);
- Local Delivery Plan (2017-2020);
- Quality Strategy (2017-2020);
- Clinical Model;
- Investing in Volunteers Accreditation (next self-assessment due 2019);
- TSH Scottish Patient Safety Programme (Mental Health);
- Supporting Healthy Choices Project;
- Active Patient Day Project.

PcIT work streams contribute to the organisational commitment around continued development of quality service delivery through the use of QI assurance and improvement methodology, supporting high quality, sustainable service delivery.

Having developed a wealth of experience, there is now an opportunity to develop a more structured approach to supporting Forensic Network partners with this discrete area of service delivery. Building on existing relationships and work streams already taking place in partnership, the PcIT are well equipped to offer a consultancy role to organisations requiring short-term input to undertake a piece of work relating to the PcIT remit.

Engaging and Involving Stakeholders

The organisation has made significant progress since the original PFPI principles were introduced in 2001, supporting an NHS culture which embraces a patient-focus to service design and delivery. The next three years will see the Board working closely with Third Sector partners to develop a number of processes through which the Hospital is able to demonstrate its commitment and readiness to ensuring that all stakeholders are supported to be fully involved in the work of the Hospital. This commitment will support a robust person-centred approach to the way in which care planning is undertaken, in collaboration with patients and carers. Key components of this work stream include demonstrating progress to TSH Equality Outcomes (2017-2021), evidencing meaningful carer involvement and developing the local British Sign Language Action Plan, due to be published by December 2018. Additionally an all encompassing policy in relation to communication needs is in the process of being developed, which informs organisational processes required to support meaningful involvement, specifically in relation to stakeholders who may experience barriers to communication e.g. Learning Disability, sensory impairment, language barriers, some of which may require electronic solutions to enable meaningful communication.

With an ever increasing requirement to realign service delivery as a result of changes to the workforce, financial constraints, legislation etc, the PcIT is now well placed to provide expertise in terms of supporting an inclusive approach to planning service change. Well established relationships with colleagues in the Scottish Health Council support an evidence based approach through the use of change methodology and QI tools. This practice has been helpful as the organisation implements the Supporting Healthy Choices project plan, in addition to providing input during periods of short-term service delivery change e.g., recovery savings plan and shaping services in the longer term as an integral part of the Service Sustainability and Transformation Group.

The increasing practice of seeking the views of stakeholders across the NHS is commendable, however TSH stakeholders are informing us that they feel over burdened with requests to share their views. A decline in engagement in this respect is notable, which may be as a result of the

number of requests. The PcIT have scrutinised a range of material in use and identified issues in respect of Accessible Information Standards and a general lack of awareness in relation to content / format, based on the needs of the respondent.
A secondary issue has emerged around independent feedback initiatives taking place across the Hospital, in relation to compiling, analysing and reporting outputs which demonstrate the learning emerging from engaging with stakeholders. The current electronic feedback system (Datix) is well used by the PcIT and should reflect the activity taking place across the Hospital, which would enable the PcIT to identify wider trends and themes for inclusion in the 'Learning from Complaints and Feedback' Report presented to the Clinical Governance Group / Committee each quarter. This more comprehensive approach will provide reassurance for the Board in respect of embedding stakeholder feedback within service design.
A consistent local approach, driven by plans to improve processes, which support a Hospital wide approach to all types of feedback will be developed. This will see a complete refresh of the annual Patient and Visit Experience Questionnaires.

Embedding Equality Within Service Design

The equality agenda has also grown significantly since the original strategy was developed, with an increasing focus on health inequalities, specifically around identifying barriers to meaningful involvement as a result of communication difficulties / disability. Embedding and evidencing equality as a key component of decision making processes at all levels is key to building person-centred services.
The equality impact assessment (EQIA) process responds to ongoing legislative changes, implemented to ensure that public authorities design and deliver services which are accessible to all. A considerable amount of work has been done to embed this process locally within every area of service delivery. However, in the longer term, the aim is to spread capacity, developing expertise specific to every area of service delivery. This approach, complimented by the use of a national electronic system, currently in the early stages of design, will enable the Hospital to access external stakeholder feedback, demonstrating a consistent and meaningful approach to inclusive service design. Building organisational capacity and expertise in this area will support the organisation in relation to strategic aims, specifically in relation health inequalities.
In support of the work streams emerging as part of the National Boards Collaborative, the PcIT are already involved in the wider equalities agenda, working closely with external colleagues to develop a process which will support the sharing of data used to inform inclusive service design from the Protected Characteristics perspective.

Following development of the Pre-Admission Specific Needs form, the PcIT are actively monitoring potential gaps, specifically in relation to ensuring equity of access to services. This process supports the Board to demonstrate a commitment to recognising and acting on potential health inequalities.
All sources of feedback, including complaints, are analysed to identify potential health inequalities, which supports a person-centred approach in terms of response and actions taken.

The Role of Volunteering in Supporting Quality Improvement

The national volunteering agenda is also moving to a more evidence based approach, with work currently ongoing to develop an evaluation tool, which will support the Board to demonstrate ongoing QI within this area of service delivery.
In response to a more tailored approach to supporting patients to engage in meaningful activity, the PcIT have developed a targeted approach to recruitment, working closely with Volunteer Scotland, whose national audience has enabled TSH to access a wider and more diverse group of volunteers seeking placements. The PcIT have been working closely with the Skye Centre Team to source volunteers with specific skill sets which complement existing skills within the

team. The use of Occupational Therapy Interest Checklists will support the spread of this practice to wards, enabling patients to access a wider choice of activities within this area.
The new Fundraiser role has been advertised, with a view to securing the input from a volunteer with experience of this area. This will enable the Board to access a range of external funding to support QI projects which may require start-up funds to support testing of change initiatives.
The PcIT are actively contributing to development of the Investing in Volunteers accreditation process, as part of a national drive to shift the focus from quality assurance to QI.
In conjunction with the Scottish Health Council Volunteering Project Lead, local volunteers and Third Sector partners, the PcIT will be refreshing the Volunteering Improvement Plan, a national tool used to support evidence of QI within the volunteering service.

Supporting the Role of Carers as Partners in the Recovery Journey

The PcIT have recently completed work to tailor the national 'Triangle of Care' tool for use in this setting, which will enable the Board to demonstrate a QI approach to supporting meaningful carer / Named Person involvement in the recovery journey. This piece of work calls for collaborative working with step-down services to ensure continuity of input as the carer transfers with the patient. This commitment will be more easily achieved by streamlining existing service delivery commitments.
The PcIT are currently engaged in a process mapping project, looking at the carer journey, in response to feedback from this stakeholder group and publication of the Carers (Scotland) Act (Scottish Government, 2016). Some duplication of input and areas in which there are gaps in input has been identified. This piece of work further highlights the issues relating to a broad approach to the involvement of 'carers', which we are learning is not always responsive to the needs of Named Persons, family/others whom the patient chooses to be actively involved in care and treatment planning and those who provide social support through visits. A number of local services have a responsibility for interacting with carers, whose role is specific to that area of service delivery however a lack of connectivity between these areas has led to some misunderstanding as to the functions of each service. Carers have suggested that a local Carer's Strategy / Policy would be helpful to clarify responsibilities for input.

Embedding Spiritual and Pastoral Care Within the Recovery Journey

Work is ongoing at a national level to refresh the 2009 Scottish Government guidance relating to embedding the role of spiritual and pastoral care within care and treatment planning. It is likely that outputs from this piece of work, led by the Scottish Health Council, will see the need for a more focussed QI approach locally to demonstrating how this element of the recovery journey is embedded within care and treatment plan objectives. Work has commenced locally, in response to patient feedback, to develop a process which will support more comprehensive sharing of information relating to involvement in spiritual and pastoral care activities, as part of our handover documentation to step-down services.

Supporting the Role of the Patient Advocacy Service

The PcIT work closely with PAS to ensure there is support in place to enable PAS to undertake their role, including attendance at PAS Board Meetings to ensure the safe involvement of the PAS patient board member and supporting the remote attendance of this patient at the PAS AGM. Monthly meetings take place with the PAS Manager to highlight any issues, discuss themes emerging from feedback and ensure PAS are included within stakeholder processes relating to service design. This regular contact helps to inform discussions which take place with the Mental Welfare Commission as part of the pre-visit process. The PcIT developed the new PAS self-assessment tool, which was completed for the first time in 2017. This tool will support PAS to demonstrate progress to key performance indicators, facilitating ongoing development of the annual PAS report shared with TSH Board, in addition to informing the Service Led Agreement tendering process which will be undertaken in 2019.

As a result of the national focus around evidence of enhanced service delivery, emerging from stakeholder experience, the PcIT will focus on building capacity in terms of supporting person-centred QI initiatives developing from feedback.
Historically, the PcIT have assumed responsibility for acting on feedback received, regularly initiating and managing improvement projects relating to Hospital wide services. This approach has limited the number of initiatives taken forward and highlighted issues in respect of directly involving staff in the area concerned. Readjusting input from 'doing' to 'supporting' compliments the role of the Hub / Skye Centre Leadership Teams, responsible for enhancing service delivery in response to feedback from their 'customers'.
Realigning the function of the PcIT provides an opportunity for a more comprehensive approach to analysing data, enabling feedback to be themed and disaggregated to ward level. A better understanding of the data will enable the service to more effectively provide support in respect of ensuring a QI focus is adopted to support tangible outputs, which demonstrate how feedback is used to develop services. Since 2014, the PcIT have developed a range of QI skills at different levels, supported by formal education and training including Post Graduate Certificate in Quality Improvement, Scottish Improvement Leadership Skills and Scottish Improvement Skills.
This better understanding of QI methodology will enable the team to develop more robust processes to include feedback emerging from the national 'What Matters to You' initiative, PAS and the MCHP process to support a more robust approach to identifying trends / themes.
Enhanced QI skills have already supported a range of QI projects within some of the wards and the Skye Centre, in addition to supporting ongoing initiatives, including projects emerging from the 'Supporting Healthy Choices' and 'Active Patient Day' work streams.

Governance

The work of the PcIT is reported through the Involvement and Equality Steering Group, with monthly meetings chaired by the Director of Nursing and AHP. The group is multi-disciplinary and includes patient, carer and volunteer representation, in addition to TSH Scottish Health Council Local Officer. External guests are regularly invited to support work streams.
The work plan includes quarterly monitoring reports relating to the Protected Characteristic Groups, the Volunteering Service, Patient Partnership Group activity, Carer Support Group input, 'Learning from Feedback', Equality Outcome monitoring, Spiritual and Pastoral Care practice, PAS feedback, Scottish Health Council update. The group reviews a number of annual reports including PAS, Disability Monitoring/ Access Needs, Complaints and Feedback.
The group also respond to national consultations, inform and review the development of PcIT QI projects and are tasked with undertaking first stage approval of the process relating to e.g. new policies, SMT / Board reports, external publications, self-assessment completions.

Key Actions

Appendix 1 provides a comprehensive overview of actions identified for input over the next three years. Key actions have been prioritised as short, medium and long term actions:

Short Term (1 year)	Medium Term (2 years)	Long Term (3 years)
Develop Patient Communication Policy (inc. BSL Action Plan)	Carer / Named Person / Visitor Experience Questionnaire	Introduce electronic EQIA System
Develop Hospital wide stakeholder involvement process	Participation Standards – increased self-assessment levels	Publish Equality Outcomes Update Report
Refresh Volunteering Improvement Plan	Spread EQIA expertise	
Implement Volunteering Evaluation Tool	Advocacy SLA tendering process – service delivery model	
Introduce Triangle of Care Tool	Local Carers' Strategy	
Patient Experience Questionnaire		

Summary

With a growing emphasis for the board to demonstrate a person-centred approach in all areas of its business, the service descriptor should more clearly define its purpose, calling for a refresh of its name.

The PcIT provide a wide range of support across the organisation in respect of discharging the Board's duties in relation to meaningfully involving stakeholders in service design, and identifying potential health inequalities, which impact on the ability of patients to work in partnership with care teams to support the recovery journey.

There is considerable work to be done to ensure that the organisation is aware of and responds to the preferred communication needs of each patient and carers who are actively involved in supporting patients. This calls for a robust, consistent Hospital wide approach, which relies on a commitment to monitor, respond quickly and provide support for any areas in which there are opportunities to improve practice.

A sharper service focus will highlight a more explicit role in terms of person-centred QI support, working closely with colleagues across the Hospital to embrace the role of stakeholders within improvement initiatives.

These achievements can only be attained with a full complement of staff in line with budgeted establishment. Recruitment to the post which has been vacant since December 2015 will therefore a priority.

"Involve us, don't just listen. Let us be the architects, the builders and the artists of our vision.
Give us tools, resources, and the hope to realise our ambition.
Don't just talk to us, walk with us,
The road that leads to change"

(Adapted from Jo McFarlane, 2013)

Appendix 1 **Person-centred Improvement Deliverables**

A wide range of deliverables have been identified as priorities over the three year period of the service delivery plan, some of which are well established and working effectively (a), many of which require further development (b) and a number which require to be designed (c):

Driver	Quality Assurance Tools	Quality Improvement Opportunities
1. TSH Service Strategy (2017-2020: *"Our care is enhanced by a dedicated independent advocacy service, and patient involvement and feedback support."* 2.TSH Quality Strategy 2017-2020: *"TSH quality vision aims to ……. achieve demonstrable improvements in outcomes including the patient experience. Demonstrate meaningful involvement of patients, carers, volunteers and all other stakeholders in quality assurance and improvement activities."* 3.TSH Clinical Model (2009): "*Patients will have the opportunity to influence service design and delivery".* 4.TSH Local Delivery Plan (2017-20) Section 7 – person-centred: Patient Experience: "*we will place patients and their carers at the centre of all service planning and delivery".* 5.Mental Health Strategy (2017-2027) – Our Vision: *"recognising service users as equal partners"* *"robustly measuring people's experiences of mental health services."* 6.TSH Equality Outcome No 3 2017-2021: "*Individual patient Care and Treatment Plans are explicit in terms of identifying and making provision for needs which may impact on a patient's ability to meaningfully engage in care and treatment processes and contribute to the review of progress".* 7.Our Voice: working together to improve	• (PAS) Self-assessment (b). • PAS Patient Satisfaction Questionnaire- including Patient Safety, Catering, Cleanliness of the Hospital, Dignity and Respect (b). • Patient Experience Questionnaire (b). • Scottish Health Council Participation Standards Self-Assessment (b). • Scottish Public Services Ombudsman (SPSO) MCHP matrix (b). • Health Improvement Scotland 'What Matters to You?' (WMTY) initiative (b). • Semi-structured feedback questionnaires eliciting views about service development initiatives, including Active Patient Day, Supporting Healthy Choices initiative, policy development (b) • Semi-structured feedback questionnaires eliciting views about the CPA process (b). • Triangle of Care tool (b). • Complaints Process Experience Feedback questionnaire (b). • Qualitative Feedback evaluation tool (c). • Equality Outcomes Action Plan (b). • EQIA Quality Assurance Tool (a).	• Advocacy SLA tendering process (2019) (b). • Wider thematic analysis of patient feedback, incorporating PAS data within 'Learning from Feedback' (LFF) Report (c). • Refresh of Patient Experience Questionnaire / process (c). • Respond to outcome of Participation Standards process and SPSO response to MCHP matrix completion – streamline processes to connect feedback and complaints (c). • Hub / Skye Centre Leadership Teams to assume ownership for delivery, outcomes and outputs, including monitoring and reporting through the LFF Report (c). • Develop policy to address potential health inequalities which arise as a result of barriers to communication, incorporating interpretation, translation, BSL, augmentative communication, Accessible Information (c). • Introduce robust process in response to concerns raised by stakeholders around gaps in communicating changes to practice (c). • Introduce Hospital wide approach to adopting a consistent format which encourages and enables all patients to share their views (c). • Equality Outcomes Action Plan outputs (b). • EQIA template and guidance reviewed to consider impact relating to additional groups (b). • Local Carers' Strategy (c).

health and social care (Scottish Health Council, 2015): "*People who use health and social care services and carers are enabled to engage purposefully with health and social care providers to continuously improve and transform services."* 8.Health and Social Care Delivery Plan (Scottish Government, 2016): *"ultimately, individuals and, where appropriate, their families should be at the centre of decisions that affect them."* 9.Rights in Mind (Mental Welfare Commission, 2017*): "With the patient's consent, have their carer involved and have their views and caring role considered when determining the need for support and services for the patient." "Have religious and spiritual needs respected and supported".* 10.Health and Social Care Standards (Scottish Government, 2017): *"I am fully involved in all decisions about my care and support."* 11.Equality Act (2010), Carers' (Scotland) Act (2016), Fairer Scotland Duty (2018),		
12.TSH Service Strategy (2017-2020) *"we have excellent volunteer involvement which brings significant added value to our service and outcomes for patients."*	• Investing in Volunteers Accreditation process (b). • Volunteering Evaluation Tool (c). • Volunteer Experience Questionnaire (c).	• Volunteering Improvement Plan (b) • Volunteer Role Development (b) • Bespoke mandatory volunteer training modules (c)

Appendix 2 The State Hospital 'What Matters to You'? 2018 Outcomes

Area	Actions Agreed	Timescale
Arran Hub	Regular, equitable access to Hub for both wards	Jan 2019
	Enhanced access to fresh air	
	Understand impact on patients of recent changes to telephone policy	
Iona Hub	MDT timetable of planned activities	Oct 2018
	Order X-Box for hub	Nov 2018
	Replace exercise bike located in Iona 3 in the hub gym	Nov 2018
	Push for Iona 1 to be part of patient shopping project	Jan 2019
Lewis Hub	Introduce wider range of ward/hub activities, including inter-ward evening social events e.g. karaoke, film nights	Aug 2018
	Provide arts/crafts materials for eves/weekends	
	Develop monthly social calendar	July 2018
	Improve physical activity – secure funding for exercise bike	Sep 2018
	Explore ways of opening the hub afternoons or evenings	
Mull Hub	Actively consider volunteer visitors as part of CTM / CPA process	Jan 2019
	Discuss at HLT and LCF how to support contact with families / carers	
Skye Centre	Craft and Design: Develop more pottery sessions, arrange more displays of patients' work, longer sessions	Dec 2018
	Gardens: Individual patient allotments, develop a sensory garden, provide educational sessions about caring for plants	May 2019
	Animal Assisted Therapy: Facilitate patient led open day to increase attendance, introduce more animals, develop information posters/booklets	Apr 2019
	Bank: Offer more privacy / personal space	
	Shop: Explore opportunity for increased access to the shop, increase range of sizes available in clothing range, develop roles for patients to volunteer in the shop	Oct 2018
	Café: Increased evening activities advertised on Onelan system, reintroduce patient café volunteer roles, open activity room for more games, relaxation/therapeutic groups	Oct 2018
	Library: More materials available for loan, use Onelan to promote books/films, introduce quiet reading area	Nov 2018
	Hairdresser: Reintroduce hair dying option, better forward planning to cover hairdresser's leave	Oct 2018
	Tinto Health Centre: Introduce debrief appt with Practice Nurse following external hospital appt, more information re. blood screening, offer tea/coffee, fruit, more reading material	Oct 2018
	Sports and Fitness: Explore evening/more regular weekend opening, establish sports walking group, re-introduce free weights	Oct 2018
	Patient Learning Centre: Explore possibility to open PLC in the evening, display patients' work, offer motivational/interactional learning	Dec 2018
		Dec 2018
		Apr 2019
Advocacy	Develop PAS promotional poster for wards, discuss patients' access to the telephone to contact PAS, include Advocacy within staff induction programme, disseminate information re Advocacy at time of admission	Oct 2018
Volunteers	Develop volunteer exit interview pro-forma, recruit volunteer guitarist for Christian Fellowship Group	Jan 2019
Carers	Review format of CPA Review Meetings to support more meaningful carer involvement, more social events, outdoor visits in summer	May 2019

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	13 December 2018
Agenda Reference:	Item No 7
Presented by:	Ann Morton, Patients' Advocacy Service Manager
Title of Report:	Patient Advocacy Service Annual Report

SITUATION

The purpose of this report is to provide assurance to The State Hospitals Board that the Patients' Advocacy Service (PAS) continues to meet the needs of the Hospital as set out in the Service Level Agreement.

2 BACKGROUND

The report highlights progress made in all aspects of the Service and improvements/achievements in the year are detailed in the report. Some highlights are noted below for Board Directors.

3 ASSESSMENT

- Full Staff compliment: Service Manager, Senior Advocate, 2 Part-time Advocates(1x3 days, 1x4 days), 1 Part-time administrator (3 days), 2 Volunteers

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- Achievements against the Key Performance Indicators in the Service Level Agreement continue to be met
- 1 year extension of Service Level Agreement ends 31st May 2019
- Recruited 1 new Volunteer
- Location in the Skye Centre increases the visibility of Advocacy and opportunities for patients to access advocacy
- Full and effective use is being made of the budget allocated by the Hospital for the service
- Robust arrangements are in place for education and supervision of all Advocates and Volunteers

- The service continues to be an integrated aspect of the Hospital landscape, positive and respectful relationships exist between both organisations
- The Additional recurring £20,000 funding received from the Scottish Government following the introduction of the Patients Rights Bill continues to assist PAS to offer the extra support that is required with new patients when they are admitted in the first 8-10weeks of their admittance

Section 9 of the main report identifies both organisational and service developments planned for the current 12 months. Of particular note to the Board will be:

- Recruitment of 2 new PAS Board Members
- Use of additional funding stream to continue to ensure PAS can deliver a suitable service to new admissions
- Continue to develop, in tandem with the Hospital, our monitoring and recording systems.
- Continue to look at developing improved and meaningful recording of outcomes for patients and stakeholders
- Support the Hospital in meeting the aspirations of the NHS quality strategy and TSH Clinical Model, particularly of the principles/priorities of person centered care
- Qualification in Advocacy- This qualification is not available to the wider advocacy movement at the moment

. 4 RECOMMENDATION

The Board is asked to note this report.

PATIENTS' ADVOCACY SERVICE
ANNUAL REPORT

1st April 2017 – 31st March 2018

TABLE OF CONTENTS

1 INTRODUCTION AND HIGHLIGHTS OF THE YEAR

The purpose of this report is to provide assurance to The State Hospital Board that the Patients' Advocacy Service (PAS) continues to meet the needs of the Hospital as set out in the Service Level Agreement (SLA).

The report describes how the service provided has the ability to adapt to the ever changing needs of the patient population, and includes a focus on the outcomes achieved for patients through engagement with PAS. Achieving the priorities for PAS team is underpinned by weekly team meetings which support the service to run effectively, for example; planning advocacy support at Tribunals, CPAs, & new admissions; ensuring that every patient has the option of advocacy to assist/support at any meetings and the admission process which can be a daunting experience for some of our new patients.

The Mental Health Act continues to impact on our service. This year we attended 59 tribunals, 2 parole board hearings and supported 28 patients to complete an Advance Statement.

With regard to Adult Support and Protection (ASP) as a service we made 1 referral, had 11 discussions pre-referral and supported 1 patient in ASP interviews.

The service dealt with 2698 issues; 1384 of these were legal (51% of the total). Hospital issues accounted for a further 8% and quality of life 28%. Of the 124 complaints recorded, 51 were formal, 4 were informal, 65 were locally resolved; 4 were not taken forward.

The Skye Centre drop-in for PAS continues to be valued and accessed by patients, with 633 contacts in the drop-in, which related to 83 patients. The number of times each patient was seen ranged from 47 patients with between 1 and 5 contacts to 7 patients with over 20 contacts; average contact 8 per patient. Feedback from patients continues to be very positive, patients tell us they like how they can drop in to speak to us formally or informally and also can phone to book a time to see an advocate. Average patient contact at the drop-in per month over the year was 53.

PAS continues to support 1 patient representative in meaningful engagement and involvement at our board meetings, the patient voice is essential to the service. We recognise that it enhances the quality of the service we provide, and signifies the importance of hearing directly from patients about their experiences in order to continue to meet the changing needs in the hospital environment. PAS will look at recruitment "succession planning" of another patient representative early in the New Year so that we continue to have a patient voice on our board.

We are actively involved in raising the profile of PAS in The State Hospital, delivering 14 advocacy inductions to new staff groups within the hospital throughout the year. We also gave a further 6 in-depth inductions to (e.g. new OT & students) who wanted to know more about Advocacy.

We have advocacy representation on key working groups including the Person Centered Improvement Group, Child & Adult Protection Forum and Mental Health Tribunal Advocacy Reference Group. The PAS Manager is a Board Member with the "Scottish Independent Advocacy Alliance" (SIAA) so that PAS can have a voice in shaping the future of Independent Advocacy and the development of new Principles in Practice for independent advocacy.

PAS held their 9TH Annual General meeting on 5th October 2018 where we delivered our Annual Report 2017-2018. Our patient representative took part in the AGM by video conference along with 2 patients from the PPG.

2 GOVERNANCE ARRANGEMENTS

The Patients' Advocacy Service has a dual accountability:

- As an independent company limited by guarantee – to the PAS Independent Board of Directors.

- As a service commissioned by The State Hospital, to report annually to The State Hospital Board, and in doing so, provide assurance that the service meets with the specification and performance targets set by the Service Level Agreement. The Person Centered Improvement Group receives quarterly reports and the service manager meets with the Person Centered Improvement Lead monthly. PAS instructed an Independent Evaluation of the service in February 2017; this was a reassurance for PAS Board that we are providing a patient focused service that meets the needs of the patient population, that we follow the Principles in Practice set out by the SIAA and that we are following our SLA agreement.

- The annual cost of the service to the Hospital this financial year was £146,585 which includes the recurring funding of £20,000 received April 2012 from the Scottish Government following the introduction of the Patients Rights Bill; reviewing advocacy provision as a consequence.

2.1 Committee Membership and Role

The Board of Directors comprises:

- Danny Reilly, Chairman
- Jo Birch, Treasurer

Board Members:

- Francis Fallan (Secretary)
- Andrew Gardiner
- Margaret Seymour
- Michael Timmons

2.2 Aims and Objectives

The Patients' Advocacy Service aims to provide an independent, highly skilled, responsible and professionally run service within the State Hospital. Whilst observing the safety and security of the Hospital, the Service works independently within it to promote patients as individuals, to support them and to enable them to be fully informed and involved in their care and treatment.

2.3 Meeting Frequency

The PAS Board of Directors held 8 Board Meetings during this year and an AGM

2.4 Strategy and Workforce

The Patients' Advocacy Service was established in 1997, with the recognition that the patients at The State Hospital are particularly vulnerable and need a mechanism of independent support and assistance that will help them access services and information. The introduction of the Mental Health Care and Treatment (Scotland) Act 2003 specifies the right to access independent advocacy for every person with a mental disorder with a specific mention to the rights of those in the State Hospital.

It is vital that the service provided to patients is flexible, efficient, independent and professional. PAS is now completely independent of The State Hospital in-line with Scottish Government legislation and the Scottish Independent Advocacy Alliance Guide for Commissioners; PAS is managed by an Independent Board of Directors.

PAS provides information, support and assistance to all patients in The State Hospital. Currently PAS has:

- 1 x full time Manager,
- 3 x Advocates (1 x full time and 2 x part-time),
- 1 x part-time Administrator
- 1 x Volunteer Advocate

2.5 Management Arrangements

The PAS Manager maintains regular contact with The Person Centered Improvement Group, The Person Centered Improvement Lead, the Director of Nursing and Allied Health Professions to ensure that there is effective co-ordination with the hospital, and that any issues can be dealt with expeditiously.

The PAS manager is a member of the Person Centered Improvement Group and gives quarterly reports to that group, as well as meeting with the Person Centered Improvement Group Lead, Sandie Dickson, on a monthly basis. The PAS Manager also attends other relevant meetings in the Hospital including the Child and Adult Protection Forum.

2.6 Training

Volunteers/Staff attend all mandatory training and continue to complete mandatory online modules in TSH that includes Health and Safety, Data Protection and level 1 PMVA.

- Advance Statement Training
- Held 2 support/training session for Volunteers and Staff
- Provided support/supervision to our Volunteers/Staff which also helps to identify any training needs

We have a weekly team meeting which volunteers can also attend; we plan our diary 2 month in advance so that we can cover patient support at CPA meetings, Tribunals, the PAS drop-in and meetings that we are required to attend. Meeting weekly allows us to make changes to the work plan that occur, i.e. change of meeting dates, it also affords time for the whole team to meet together and discuss any issues or patient information that everyone needs to be aware of.

PAS welcomes the opportunity to take part in the training and development offered by the State Hospital, as it affords the opportunity to develop productive and respectful relationships with TSH staff.

We actively encourage staff/volunteers to apply for training and continue personal development. At the moment we are supporting and contributing some financial assistance to 2 staff members in Year 3 of the "MSc Forensic Mental Health" course, we also have a staff member in year 4 of a Psychology degree.

2.7 Policies and Procedures

All PAS policies and procedures were reviewed and updated before the Independent Evaluation in 2017. We have since reviewed and renewed most of our policies to encompass and reflect the changes in General Data Protection Regulations (GDPR)

2.8 Participation / Integration

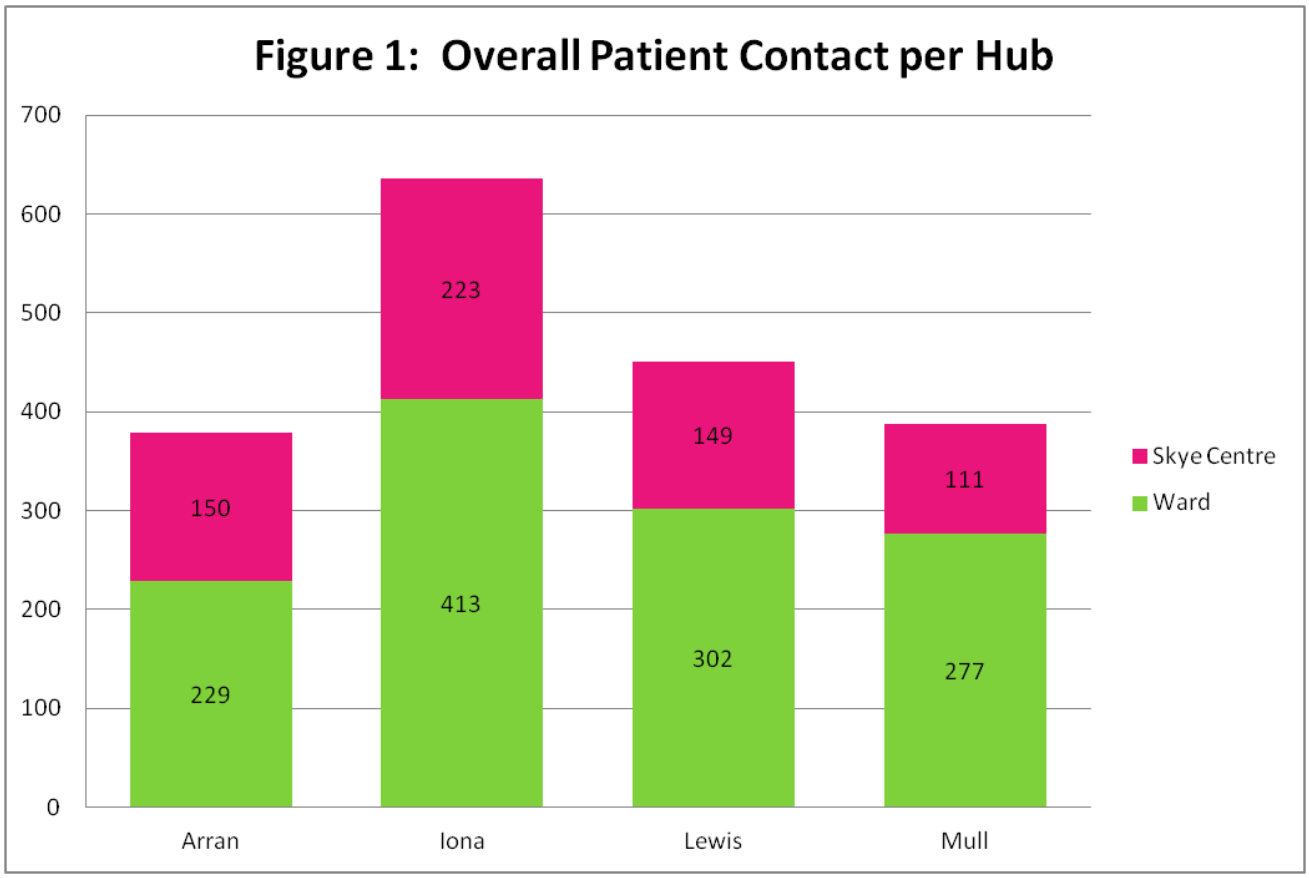
PAS staff participated in a number of State Hospital groups to facilitate and support integrated ways of working that benefit patient care e.g. Person Centered Improvement Group, Patient Partnership Group (PPG) and Child & Adult Protection Forum.

Staff participated in a number of groups outside the Hospital, including: the Scottish Independent Advocacy Alliance (SIAA), Mental Health Tribunal Advocacy Reference Group, and Independent Advocacy Reference Group.

3 Key Performance Indicators

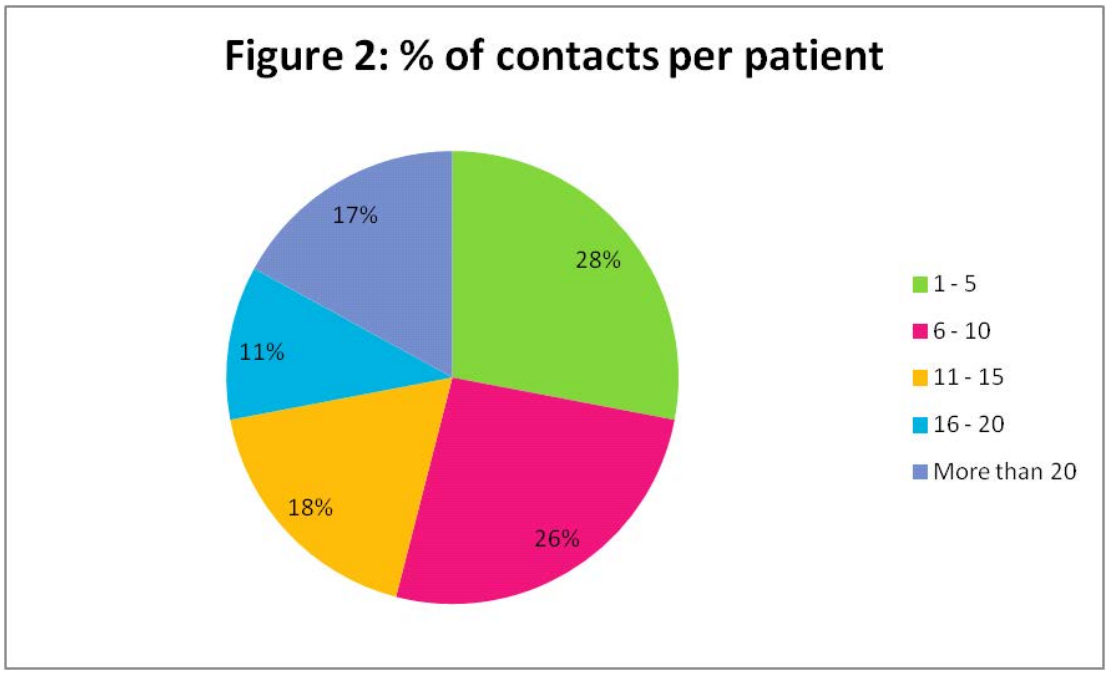
3.1 Ward/Skye Centre Contacts

As seen in figure 1, the highest number of patient contact continues to be Iona Hub which we believe is because one of the wards in the hub is a specialty ward for Learning Disabilities. The average number of contacts per patient was 14. These figures include the 33 patients that were either transferred to medium secure units or returned to prison and the 30 admittances during this period.



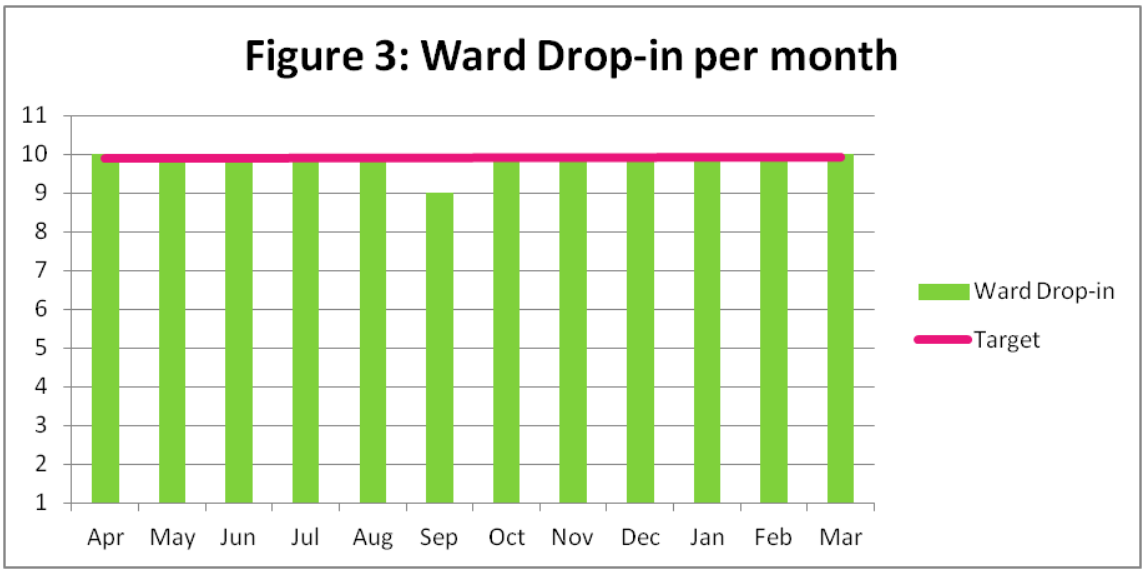
3.2 Overall Patient Contact

133 patients had 1854 contacts during the year; all patients' with-in the State Hospital were seen at least once by an advocate. The graph shows 28% of patients were seen between 1-5 times with a further 17% seen more than 20 times. The average number of contacts per patient was 14. We regularly monitor how much contact each patient has and address any concerns with the patient and also the advocate involved, this is usually addressed during Supervision with staff.



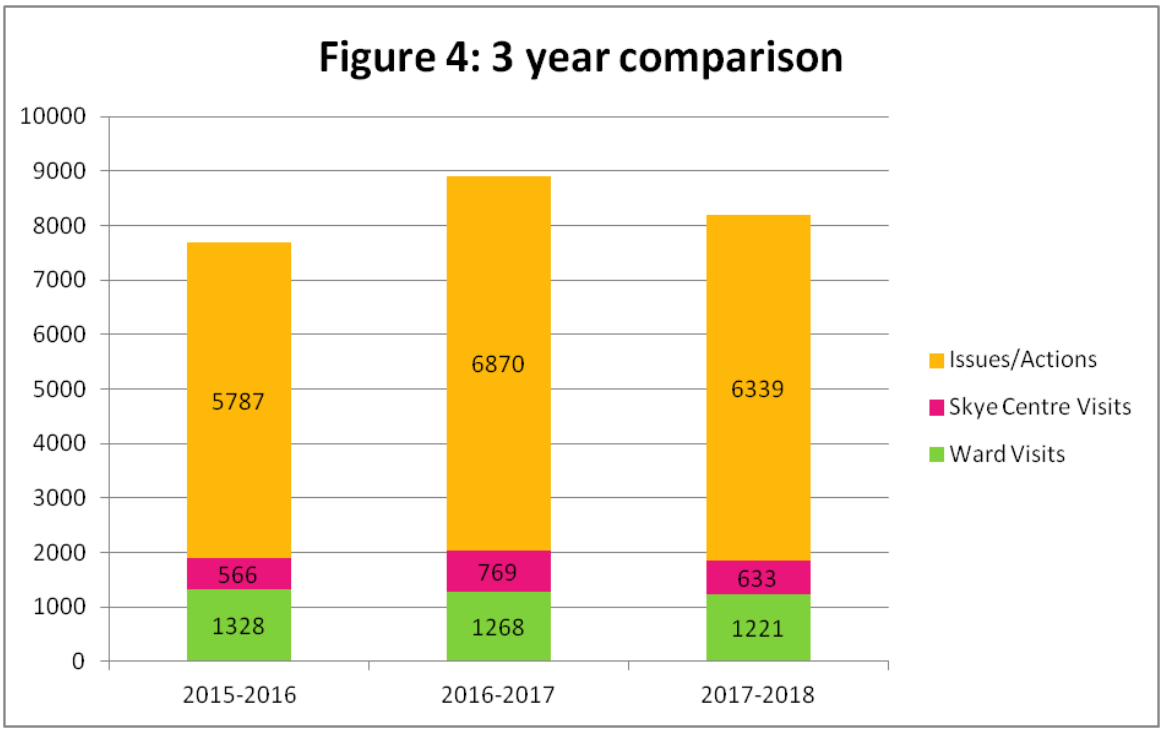
3.3 Attendance on wards

The Service Level Agreement requires the service to provide a drop in service to each ward once per the graph below shows the number of ward drop-ins throughout the year.



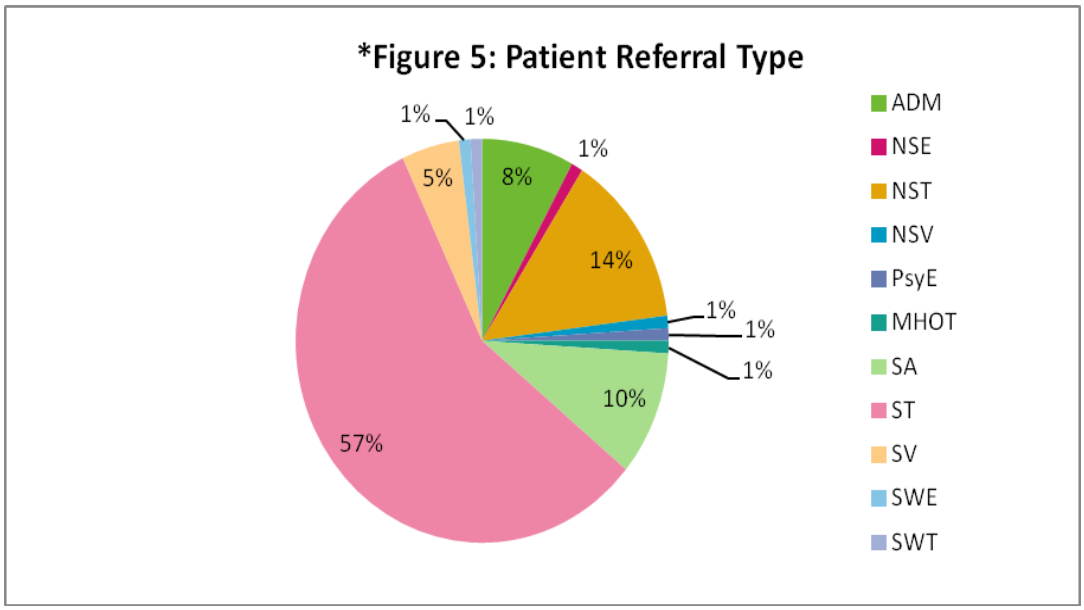
3.4 Year comparisons (2015-2016, 2016-2017, 2017-2018)

The figures around patient contact have remained consistent for the past 3 years.



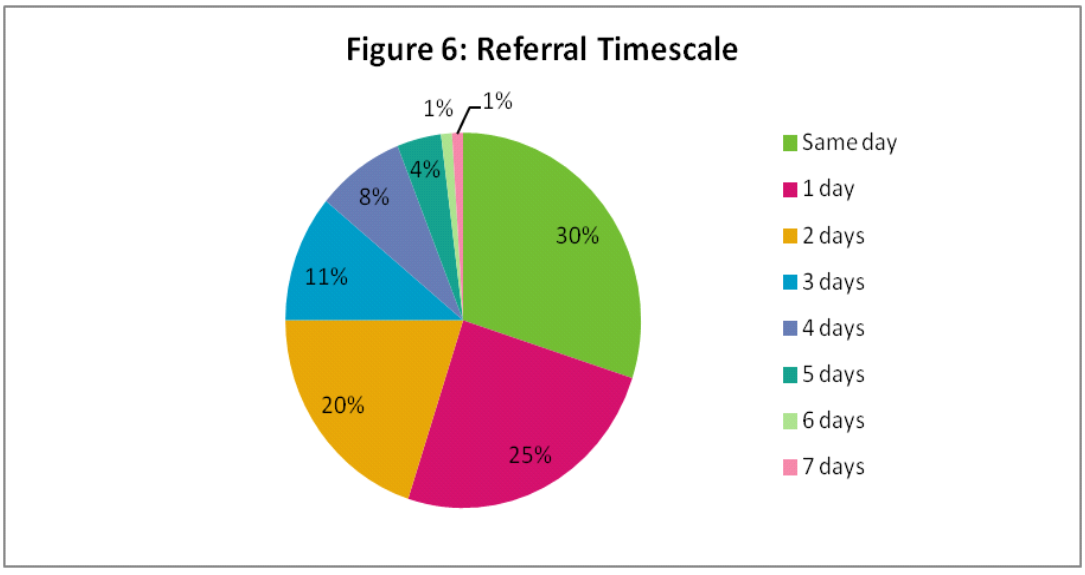
3.5 Formal Referral Routes

These statistics relate to formal requests for contact with an Advocate (as opposed to informal contact at ward drop-ins, Skye centre drop-ins or community meetings) but are a subset of the overall contact statistics in section 3. 67% of referrals are from patients themselves via the PAS free phone. * See Appendix 1.



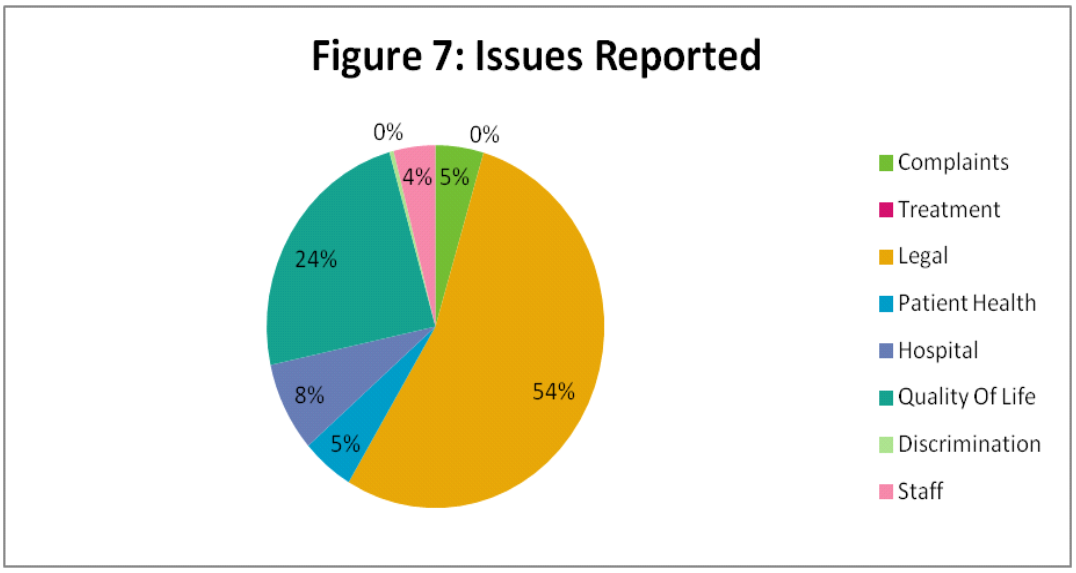
3.6 Patient Referrals Timescales

The Service Level Agreement requires that all patients should be seen within 7 working days of referral. PAS continues to work to a 5 day timescale, 7 patients were seen out-with our own target of 5 days; 100% of referrals were seen within 7 days.



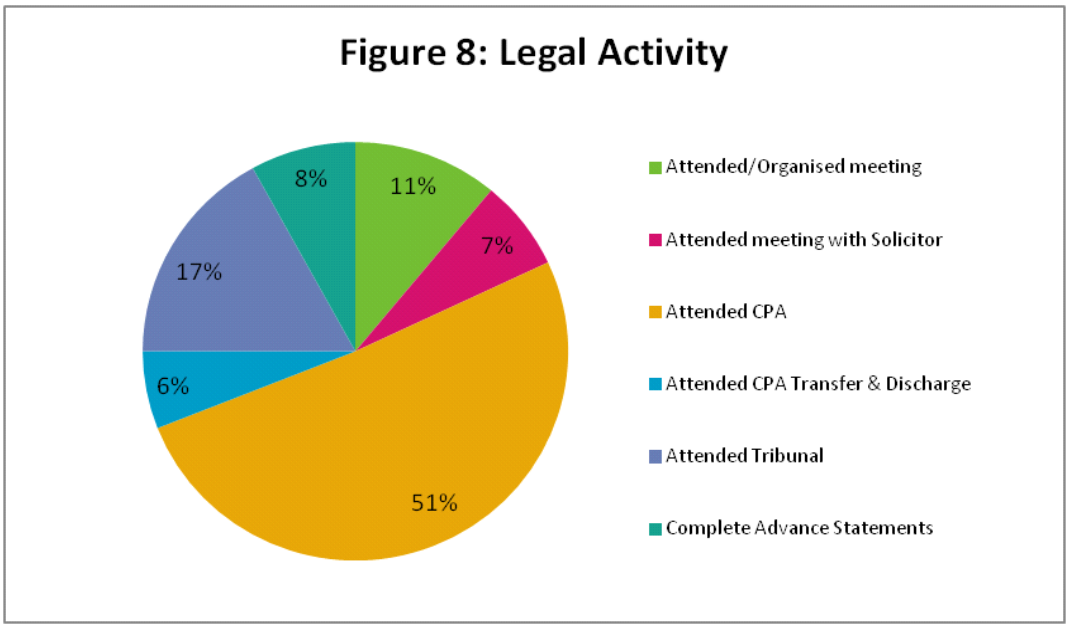
3.7 Issues

The service dealt with 2698 issues; 1384 were legal (51% of the total). Hospital issues accounted for a further 8% and quality of life 28%. 124 complaints were recorded, 51 formal, 4 informal, 65 resolved locally and 4 not taken forward.



3.8 Case Reviews, CPA and Tribunals

The activity classified as legal was associated with supporting patients at formal meetings: solicitor meetings, CPAs and tribunals.



4 COMPARISON WITH THE LAST ANNUAL REPORT

	IDENTIFIED AREAS OF WORK	ACHIEVED
Organisational	Recruit New Board Members	1 new Board Member
	Continue to develop and review recording system for statistical information focusing on outcomes	Ongoing, added new coding to reflect diversity of work , and tailored graphs used for reporting purposes
Service	Continue to have patient participation and involvement on PAS Board of Directors	Patient representatives in place since October 2010. 1 patient rep on board contributing to Board Meetings and AGM. Recruitment of 1 other patient as part of succession planning 2019.
	Continue a positive relationship and open communication with the State Hospital Board and Hospital staff	Monthly meeting with Person Centered Improvement Group, reports to Person Centered Improvement Group Annual Report to The State Hospital Board of Directors.
	Complete Tender process for SLA 2019, current SLA due to expire 31/06/2018	

5 AREAS OF GOOD PRACTICE / OUTCOMES DEVELOPMENT

We continue to ensure that the service meets the needs of the hospital and the ever changing patient population:-

- Annual patient questionnaire/survey
- Review of Policies and Procedures completed prior to Independent Evaluation
- Regular supervision and annual appraisals of staff/volunteers
- Ongoing staff development and training
- Regular review of Skye Centre drop –in facility
- Approachable, unbiased and visible service
- Independent Evaluation completed 2017

6 OUTCOMES

We continue to work towards producing meaningful outcomes about the service we provide for the Hospital and the Patients.

In this report reported outcomes centre on Case Reviews, Care Programme Approach Meetings, Tribunals and Parole Board hearings; we differentiate between Tribunals & Parole Board Hearings as they are separate legal processes. We also support Advance Statements and wills,

The delivery of information searches and local issue resolution give a further insight to some of the pieces of work we do with patients that give positive outcomes for the patient group. We are starting to record in the coming year the different meetings we attend with patients i.e. Skye Centre community meeting, Keeping you informed (PPG) "Meeting with solicitors" and will use anonymous Patients stories to illustrate the impact of contact with PAS.

Tribunal Outcomes

Discussion	*Patient Outcome*	*Hospital Outcome*	*Total*
Total 216	Patient knows and understands legal rights and Mental Health Tribunal	Patient aware of legal rights and afforded access to Advocacy support and solicitor	**65**
	Patient knows and understands legal rights and Mental Health Tribunal Patient able to attend meeting independently with solicitor	Patient declined Advocacy, solicitor in attendance	**6**
	Patient felt supported and views made clear through prepared personal statement	Patient was supported to attend Tribunal, to have his voice heard, contributing in the process and feeling part of it	**59**

Case Review Outcomes

Discussion	*Patient Outcome*	*Hospital Outcome*	*Total*
Total 447	Patient felt prepared, supported and involved with questions prepared	Patient involved and participating in CPA process with advocacy support	**178**
	Patient able to attend meeting independently, prepared questions with advocacy	Patient involved and participating in CPA process	**26**

Other Activity Outcomes

Discussion	*Patient Outcome*	*Hospital Outcome*	*Total*
Total 138	**Completion of Advance Statements**: Patients wishes expressed regarding future care	Future needs identified and patient's wishes on how they would expect to be treated	**28**

	and treatment in a legal document	should they become unwell and are unable to make decisions regarding their care and treatment	
Total 41	**Formal complaint**: Patient able to express dissatisfaction and have issues investigated by the complaints officer, voice being heard	Patients complaint actioned and investigated	**51**
	Information search: Information gathered due to patient not being able to access the internet	Patient able to access information	**107 Average 9 per month**
	New Admissions: Patient understands role of Advocacy, their rights and how to contact us	Hospital met legal obligation to provide Advocacy services	**30**
	Patient supported during meeting (Solicitors, Independent Doctors, Social Worker, etc): Patient felt supported during meeting having someone they know with them, take notes to feedback to patient later and have their voice heard, etc.	Patients supported to attend meeting and be involved Hospital met legal obligation	**62**
Discussion	***Patient Outcome***	***Hospital Outcome***	***Total***
	Local Resolution: Patients issue resolved through discussions with relevant people and patient, quickly reduces anxieties and worries	Issues resolved at ward level (issues/complaints not formally taken forward). Hospital quickly addresses issues saving staff time, unnecessary complaints and situations resolved to patient satisfaction	**45**
Total 11	**Adult Protection Support**: Concerns addressed and appropriate action taken when patient feels at risk	Needs of vulnerable patient addressed independently through adult support and protection investigation	**2**
Total 52	**Discharge/Transfer CPA**: Patient able to attend meeting independently	Hospital ensures that the appropriate plans are in place. Statutory obligation	**1**
	Attend Discharge/Transfer CPA: Patient involved in care & treatment which includes a future moving on plan	Hospital ensures that the appropriate plans are in place. Statutory obligation	**23**
Total 18	**Parole Board Hearing**: Patient felt supported to attend the hearing with an advocate that were comfortable with	Legal rights met, participation in the process	**2**

7 Patient Stories

Engaging with Advocacy

Patient X was always polite to Advocacy however never engaged until he suffered with a medical issue which resulted in an investigation. In the period of 2017-2018 we supported the patient to find a solicitor and accompanied the patient at any solicitor meetings as well as supporting the patient during an interview regarding the investigation. We also supported the patient to submit a claim to the hospital which he won and was awarded a sum of money which Patient X was grateful for due to his financial situation. This process helped Patient X to build a positive relationship with his advocacy worker which allowed the patient to feel comfortable having advocacy present during his case reviews and tribunal which he had never done previously. Patient X is now better represented as he does not attend meetings. Additionally, Patient X divulged he had suffered from childhood abuse and wished to complete some psychology work however the clinical team didn't feel he was ready. After much discussion and deliberation, the clinical team agreed to begin the first stages of the work which was a huge step for Patient X. There were additional matters raised throughout the period such as updating his advance statement and submitting a complaint. All pieces of work included time and building the patients trust in advocacy. Patient X is now much more comfortable in approaching advocacy and utilising the support we can give.

0 Physical Health	1	**6 Information Search**	1
0 Critical Incident Reviews	3	**9 Attended/Organised Meeting**	1
0 Complaints (Other)	1	**9 Attended CPA**	2
2 Advance Statement - Discussion	3	**9 Attended meeting with Solicitor**	3
2 CPA - Discussion	6	**9 Complaint (Stage 1)**	2
2 Legal Aid Funding	1	**9 Fill out Forms**	1
2 Medical Records	1	**9 Complete Advance Statements**	1
2 Solicitor	8	**9 Gathered Information**	13
2 Tribunal - Discussion	3	**9 Letter/Mail**	7
2 Legal (Other)	3	**9 Read report to patient**	1
4 Treatment/Medication	1	**9 Email**	15
5 Hospital/Policy/procedure	1	**9 Phone Call**	17
5 Hospital (Other)	4	**9 Tribunal**	1
6 Family and Friends	1	**9 Visit/Diary Note**	2
6 Placements	1	**9 Skye Centre Drop-in.**	9
6 Quality of Life (Other)	1	**Totals:**	115

Patient/Hospital Outcomes

• Patient has advocacy representation at meetings and his voice is heard through Advocacy
• Patient supported through CIR, claim and complaints process. Complaint and issues resolved
• Clinical Team agreed to psychology work which will aid his journey to moving on. Patient engaging with clinical team
• Advance statement updated. Clear statement in place with patient wishes

Grounds Access

Patient X approached advocacy regarding his ground access. He had been informed at his case review grounds access had been agreed and an application would follow shortly. Patient X approached advocacy on this issue seven weeks later as he had still not got his ground access. He had been told it had been applied for three weeks earlier despite being agreed at his CPA seven weeks earlier but the form had been sent back to the ward as it had not been completed correctly. He was then told this had been rectified and the form had again been sent for approval. However, it came back a second time due to again not been completed correctly. Patient X was by this time frustrated and angry it was taking so long especially as having ground access was necessary for the patient to be referred to a medium secure hospital.

Advocacy were able to support the patient to make a formal complaint detailing the issue, his feelings around this and the impact it had on the patient moving on. Through the support of Advocacy the patient was able to correctly navigate the complaints procedure, expressing himself in a clear and coherent manner. This allowed the hospital to understand the impact this was having on his mental health and his future pathway out of the TSH.

0 Quality of Life	1	**9 Attended/Organised Meeting**	3
0 Treatment	1	**9 Attended CPA**	1
2 Level of Security	1	**9 Attended meeting with Solicitor**	1
2 Solicitor	3	**9 Complaint (Stage 1)**	1
2 Tribunal - Discussion	5	**9 Gathered Information**	1
2 Legal (Other)	2	**9 Letter/Mail**	1
4 Treatment/Medication	5	**9 Email**	5
4 Patient Health (Other)	1	**9 Phone Call**	6
5 Patients Property	1	**9 Referral to Other advocate**	1
6 Grounds Access	2	**9 Tribunal**	1
6 Procurement Enquiry	1	**9 Visit/Diary Note**	5
8 Staff (other)	1	**Totals:**	52

Patient/Hospital Outcomes

- Patient got his grounds access
- Complaint made and upheld

Voice heard and appropriate action taken

Patient X was a readmission to TSH and had regularly used Advocacy before being discharged. In the period of April 2017 to March 2018 patient X was supported on a number of occasions with various issues. Patent X had a Life Prisoner Tribunal coming up and requested Advocacy support at this hearing. Advocacy doesn't have an automatic right to attend Life Prisoner Tribunals however permission was sought from The Parole Board and granted. The Life Prisoner Tribunal was attended by both the patient and Advocacy.

Patient X wanted to appeal his order and return back to Prison however didn't have a Mental Heath Solicitor. We supported patient X to go through the solicitor list and contacted his chosen solicitor on his behalf. The first solicitor selected was not taking on any new clients however the second solicitor agreed to take on patient X and arranged to come out and visit the patient the following week. Patient X approached Advocacy about his medication being given in the morning and feeling really tired and having no motivation all day. Advocacy supported patient X by contacting his RMO and asking for his medication times to be changed to the evening. This was agreed and patient X felt a lot better after the change. There were other issues raised throughout the period such as; supporting patient X at CPA, support to request an increase in placements and information searches for easy read guides on legal issues.

2 CPA - Discussion	5	**8 Staff (other)**	1
2 Parole Board	2	**8 RMO**	3
2 Prison	7	**9 Attended CPA**	1
2 Solicitor	7	**9 Gathered Information**	11
2 Tribunal - Discussion	4	**9 Letter/Mail**	1
2 Legal (Other)	4	**9 Read mail to patient.**	1
4 Treatment/Medication	6	**9 Email**	7
5 Benefits	1	**9 Phone Call**	6
5 Hospital (Other)	3	**9 Tribunal**	1
6 Placements	1	**9 Visit/Diary Note**	6
6 Quality of Life (Other)	1	**9 Skye Centre Drop-in.**	10
6 Information Search	1	**Totals:**	90

Patient/Hospital Outcomes

- Attended with support of Advocacy at LPT, his voice was heard
- Legal rights were met
- Patients wishes taken on board, his voice was heard , continued engagement with Clinical Team
- Information provided in appropriate format

8 FUTURE AREAS OF WORK AND SERVICE DEVELOPMENTS

8.1 Organisational

We need to ensure that all staff and volunteers are kept up to speed with any legislation changes that may affect our work with patients; training is an important part of this process:-

- Provide 2 training days for Board Members, Staff and Volunteers
- Ongoing training for Staff/Volunteers
- Complete Annual Report
- Organise AGM
- Recruit Volunteers
- Plan succession for Patient Representatives on PAS Board
- Complete Tender paperwork for Service Level Agreement

8.2 Service

As a service we continue to look at ways to improve in the following areas:-

- Continue to develop improved recording system for statistical information and outcome measures
- Continue to review and monitor how we deliver the service
- Continue to look at developing patient participation with PAS
- Continue monthly drop-ins in all wards
- Continue a positive relationship and open communication with the State Hospital Board and Hospital staff
- Review of patient Survey (questionnaire) with PPG for 2018
- Support the Hospital in meeting the aspirations of The NHS Quality Strategy and TSH Clinical Model, particularly on the principle of persons continued care.

As a service we are

- Planning to go paperless in the New Year
- Have an active Twitter Page
- Obtain complete independence from TSH and have our own Dedicated cloud based server within the EU. This meets the requirements of GDPR and the recommendations from the Scottish Independent Advocacy Alliance(SIAA)

9 Ethnicity Group Contacts for all Patients between 01st April 2017 – 31st March 2018

This table demonstrates that the service provides support to patients from all ethnic backgrounds equally and continually monitors this.

Ethnic Group	Pas Code	No of Patients	Percentage	No of Contacts	Percentage
Chinese, Chinese Scottish, Chinese British	3E	0	0%	0	0
Asian, Asian Scottish, Asian British	3B	1	0.75%	38	2.05%
African, African Scottish, African British	4B	2	1.50%	32	1.73%
White Scottish	1A	54	40.60%	769	41.48%
White English	1D	2	1.50%	17	0.92%
White Irish	1C	6	4.52%	132	7.12%
White Other	1B	4	3.00%	31	1.67%
White British	2A	39	29.33%	532	28.69%
Other Ethnic Background	1E	9	6.77%	144	7.76%
Unknown		16	12.03%	159	8.58%
	Total	133	100%	1854	100.0%

10 FINANCIAL REPORT

Schedule to the Financial Activities
For the period from 1 April 2016 to 31 March 2017

	£	£
Gross Income	146,684	
Gross Expenditure	149,565	
		(2,881)
Incoming Resources		
Government Funding	146,585	
Bank Interest	99	
	146,684	
Cost of Charitable Activities		
Employment Costs	143,655	
Establishment Costs	1,400	
Print, Post, Stationery	575	
Subscriptions and donations	200	
	145,830	
Governance Costs		
Accountancy Fees	2,040	
Professional Fees	1,695	
	3,735	
Total Resources Expended as per Account		**149,565**
Cash & Bank Accounts	**47,971**	
Liabilities payable in one Year	5,961	
Net Current Assets	**42,010**	

11 NEXT REVIEW DATE

The Patients' Advocacy Service Annual Report will be available to The State Hospital Board from September 2018.

12 APPENDIX 1

Figure 5, abbreviations:-

ADM – Admission

NSE – Nursing Staff Email

NST – Nursing Staff Telephone

NSV – Nursing Staff Verbal

PsyE – Psychology Email

MHOT – Mental Health Officer Telephone

SA – Self Answering Machine

ST – Self Telephone

SV – Self Verbal

SWE – Social Work Email

SWT – Social Work Telephone

Board Paper 18/82

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	13 December 2019
Agenda Reference:	Item No: 8
Author(s):	Chair of the Clinical Forum
Title of Report:	Clinical Forum – Update
Purpose of Report:	For noting

1 SITUATION

The Clinical Forum was established in the final quarter of 2017 and is therefore coming to the end of its first year.

2 BACKGROUND

The Clinical Forum will meet four times during 2018 and will form an advisory committee to the Board. There has been a focus on establishing itself as a clinical advisory group within The State Hospital.

3 ASSESSMENT

A briefing has been prepared to outline progress to date and this is attached. The Clinical Forum will continue to update the Board on its work through submission of its minutes. An Annual will be prepared for submission to the Board at its meeting on 28 February 2019.

4 RECOMMENDATION

The Board is invited to **note** work to date to establish the Clinical Forum within the hospital.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	
Workforce Implications	eg Considered in Section 3 of the report
Financial Implications	eg No financial implications if approved
Route To Board Which groups were involved in contributing to the paper and recommendations.	eg Clinical Forum / Patient Forum / Medical Advisory Committee / other
Risk Assessment (Outline any significant risks and associated mitigation)	
Assessment of Impact on Stakeholder Experience	
Equality Impact Assessment	

The State Hospital Clinical Forum Briefing

The State Hospital's Clinical Forum is coming to the end of its first year of work. We spent the end of 2017 establishing our membership. We have met three times to date, with one meeting due to be held in December. One meeting at the start of the year was cancelled due to adverse weather, and one was rescheduled due to the number of apologies.

Our membership is currently:
Dr Aileen Burnett – Consultant Forensic Clinical Psychologist (Chair)
Dr Sheila Howitt – Consultant Forensic Psychiatrist (Vice Chair)
Carolin Walker – Professional Nurse Advisor
Sandie Dickson – Person Centred Improvement Lead
Jim Irvine – Clinical Security Liaison Manager
Peter de Mascio – Social Work Team Leader
Fiona Warrington - Pharmacist
Sarah Innes – Occupational Therapist
Shelia Smith – Clinical Effectiveness Team Leader
Alan Blackwood – Senior Charge Nurse
Lesley Murphy – Advanced Nurse Practitioner

Admin support provided by Kellie Gourlay

Our work in 2018 has concentrated on establishing ourselves as a clinical advisory group. We have focused on raising awareness of the Clinical Forum among the workforce, and seeking out areas of work which we may be able to support. To this end we have written to the chairs and leads of groups, departments and committees within the hospital to offer our support. These included:

- Clinical Leads for each hub
- Physical Health Steering Group
- Mental Health Practice Steering Group
- Medical Advisory Committee
- Involvement and Equality Service
- Patient Safety Group
- Quality Improvement Group
- Relational Approaches To Care Group
- Trauma Informed Care Group
- Child and Adult Protection Group
- Infection Control Committee
- Corporate parent group
- Security Group
- Patient Day Group
- Healthy Living Group

- Service and Sustainability Group
- Nursing and AHP Advisory Committee
- Psychology Professional Practice Meeting
- Psychological Therapy Nurses Professional Practice Meeting
- Clinical Governance Group
- Realistic Medicine Lead

We also produced a Staff Bulletin to raise awareness of our function and role among the wider workforce.

We spent our initially meetings discussing our approach to our work within our setting, taking cognizance of the unique setting we operate within, but also the common challenges, strategies and opportunities that come from working within NHS Scotland.

One of the most exciting pieces of work within TSH as a whole in 2018, which we hope to drive forward into 2019, was the TSH3030 initiative. The Clinical Forum is committed to supporting TSH realise the Chief Medical Officer's Realistic Medicine agenda, and believe that the 3030 initiative was a transformative step towards this. We will be contacting all 3030 project leads to offer our support in continuing their great efforts to improve our service.

We have been approached by the board's Realistic Medicine Clinical Lead, Dr Gordon Skilling, to work alongside him in running a series of workshops in Spring 2019. These workshops will be focused on developing our ability to work in a Shared Decision Making fashion, and harnessing our workforce's experience and enthusiasm to work up ideas to test using a quality improvement framework.

In summary, 2018 has seen the firm establishment of The State Hospital's Clinical Forum, and promoting awareness of our existence and role within the organisation. Looking forward to 2019, we want to work closely with the Realistic Medicine Lead and Quality Improvement Team to drive forward the great work started in TSH3030 and keep the momentum and appetite for improvement moving forward.

Dr Aileen Burnett
Consultant Forensic Clinical Psychologist
Chair of The State Hospital Clinical Forum
December 2018

Board Paper 18/ 83

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	13 December 2018
Agenda Reference:	Item No: 9
Sponsoring Director:	Medical Director
Author(s):	Head of Corporate Planning and Business Support
Title of Report:	TSH3030 – promoting quality improvement with local teams
Purpose of Report:	Update on TSH3030 initiative for Quality Improvement

1 SITUATION

The State Hospital has developed a Clinical Quality Strategy 2017 – 2020, this sets out the direction, aims and ambitions for the continuous improvement of clinical care in the hospital. There has been an investment in providing support to build capability for Quality Improvement across the hospital through staff taking part in nationally offered training programmes such as Scottish Implement Leaders (ScIL) programme, Scottish Improvement Foundation Skills (SIFS) Programme and Scottish Quality and Safety (SQS) Fellowship. This paper outlines an initiative to support the achievement of the quality goals and further embed a culture of quality improvement, in teams across the hospital through an initiative TSH3030

2 BACKGROUND

The Clinical Quality Strategy 2017 – 2020 contains the following 7 goals to ensure the organisation remains focussed on delivering our quality vision:

1. Setting and delivering ambitious quality goals to support the provision of high quality care and services to our patients and carers;
2. Engaging staff, patients, carers, volunteers and other stakeholders in improving our quality of care;
3. Ensuring that everyone in the organisation understands their accountability for quality and are clear about the standards expected of them;
4. Gaining insight and assurance on the quality of our care;
5. Ensuring access to and understanding of improvement data to build a positive momentum in relation to quality improvement;
6. Evaluating and disseminating our results;
7. Building improvement knowledge, skills and capacity.

The State Hospital has been involved in designing and delivering quality improvement programmes, including the patient safety programme for many years. The need to focus on continually improving quality of care for patients is ongoing and has challenges with both operational and financial pressures. *Improving* quality and reducing costs to deliver better outcomes at lower cost (improving value), can be achieved for example by reducing unwarranted variations in care and addressing overuse, misuse and underuse of treatment. There are many examples across the NHS showing that even relatively small-scale quality improvement initiatives can lead to significant benefits for patients and staff, while also delivering better value

Realistic Medicine (RM) is the Chief Medical Officer (CMO)'s strategy for sustaining and improving the NHS in Scotland. It is the CMO's vision that, by 2025, all healthcare professionals in Scotland will demonstrate their professionalism through the approaches of RM.

The six key themes of RM are:

- Building a personalised approach to care
- Changing our style to shared decision making
- Reducing harm and waste
- Becoming improvers and innovators
- Reducing unwarranted variation in practice and outcomes
- Managing risk better.

The Kings Fund in association with The Health Foundation published a paper in October 2017, titled 'Making the Case for Quality Improvement: lessons for NHS Boards and leaders'[i]. This paper outlined 10 lessons for NHS Leaders to provide a starting point for leaders to embed quality improvement in their work. These are set out below:

- Make quality improvement a leadership priority for boards.
- Share responsibility for quality improvement with leaders at all levels.
- Don't look for magic bullets or quick fixes.
- Develop the skills and capabilities for improvement.
- Have a consistent and coherent approach to quality improvement.
- Use data effectively.
- Focus on relationships and culture.
- Enable and support frontline staff to engage in quality improvement.
- Involve patients, service users and carers.
- Work as a system

3 ASSESSMENT

A quality improvement (QI) network formed across the hospital in April 2018 to support the use of quality improvement methods, build capacity and capability and promote engagement of staff in quality improvement. The QI network identified an initiative, originally developed in NHS Ayrshire and Arran, which enabled and engaged staff in quality improvement. Following discussion with NHS Ayrshire and Arran and with Executive Team members, the QI network agreed to trial the TSH3030 initiative to enable and engage staff in quality improvement activities. The TSH3030 initiative invites teams to form and spend 30 minutes a day for 30 days on a quality improvement project.

A quality improvement event was held on 3rd October, hosted by the QI network to present current QI projects, the TSH3030 initiative was launched at this event. Entries were invited and encouraged from teams across the hospital. Each team committed to take 30 minutes a day for 30 days working to develop and test ideas for making improvements. Team were supported by mentors from the QI network. The TSH3030 imitative ran from 5th November until 5th December. In total 27 entries were submitted and 23 projects completed the month of QI. Appendix 1 provides a summary of the projects and their aims.

TSH3030 projects displayed their work and weekly updates in the hospital foyer, making the initiative visible for all staff entering and leaving the building. Weekly updates from teams were reviewed by the Executive Team who awarded the 'Team of the Week' award. This award was given for teams who have made most significant progress. Updates on the winning and commended teams were posted on the intranet each week. At the end of week 4, final posters were developed by teams, summarising what they had learned, what impact the teams work had had and what their next steps are. The Executive Team were invited to judge the final posters and a range of awards have been identified.

An awards ceremony, the TSH3030 Improvement Oscars is being held on 13th Dec with all teams being invited to present their work and receive recognition for the progress made. There has been significant interest from external Quality Improvement leaders around this initiative and although they cannot attend the awards event, are interested in hearing more about the impact of this activity. Weekly tweets were sent from staff personal account to connect this QI initiatives to other QI forum. We plan to submit a paper on the impact and learning form this imitative to the NHS Conference in June.

A learning and review meeting is planned for later in December and an evaluation is planned going into 2019. Some teams have committed to continuing their TSH3030 project, they will continue to be supported by mentors from the QI network. It is hoped that the QI network can be expanded across the hospital to include those involved in the TSH3030 initiates. Staff members who have demonstrated interest in QI can be further supported to develop their skills, knowledge and capabilities.

4 RECOMMENDATION

The Board is invited to note the Quality Improvement initiative, TSH3030

The Board is invited to attend the TSH3030 Improvement Oscars in the Canteen on 13th Dec 2 – 3pm and engage with the teams who have developed their work

[1] Kings Fund 11th Oct 2017 Making the case for quality improvement: lessons for NHS boards and leaders, H Alderwick et al

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Clinical Quality Strategy
Workforce Implications	No workforce implication identified
Financial Implications	No financial implications
Route To Board Which groups were involved in contributing to the paper and recommendations.	Paper presented to Board for information, previous paper had been presented to SMT for information
Risk Assessment (Outline any significant risks and associated mitigation)	Risk are managed through collaboration with Directors and SMT
Assessment of Impact on Stakeholder Experience	Nil
Equality Impact Assessment	Nil

Appendix 1 TSH3030 Teams

Team Name	Main Contact	Project Aim	Measure
Plants Not Plastic …	Georgia Regan	We aim to become the only totally plastic free NHS Staff Dining Room in Scotland	Wastage, reduction in usage, costings/savings, customer comments/feedback, better for the environment, promoting responsible recycling
Referral Dam Busters	Alex MacLean / Sarah Innes	To improve the speed of access to the Skye Centre activity areas	Demonstrated by a decrease in time taken from initial discussion about Skye Centre attendance at CTM to the patient being allocated a session in an activity centre. Baseline data can be gethered from existing referral forms.
HCSW Compliance Crusaders	Sharon Corrigan	To improve compliance with the NHS Scotland Healthcare Support Worker mandatory Induction Standards.	Mandatory induction standards workbook completion rates, time taken by individuals to complete the workbook, percentage of completions within the mandated completion timescales, feedback from HCSW and mentors
Statistical Storm Troopers	Julie McGee	Improve the way we communicate with the wards re audit and VAT data.	Audit and VAT data would be more visible in all wards with nursing staff having an understanding of why the audit is done, what the results showed and any good practice that they could either share with others or obtain from others.
iMAP	Jean Byrne / Gayle Scott	Improve completion rate of iMatter Action Plans	Measure and monitor the number of iMatter Action Plans that become completed on the iMatter portal.
"But there isn't a policy for this!"	Dr Beth Cameron	To increase the amount of unprompted patient contact time junior doctors have with our patients. We aim to each spend 30 mins of every day that we are in the hospital in direct, face to face, contact with our patients.	We will measure the frequency of patient reviews by looking at documentation on RiO. This could easily be contrasted to the frequency of reviews on RiO from the previous month.
Grub matters!	Leanne Tennant	Increase the use of the Patient Meal Service Feedback system within Iona 2. Develop easy read format for providing feedback and receiving responses	Number of Meal Service Feedback Forms submitted, number of responses received, satisfaction levels relating to response to feedback
Team Greatix	Aileen Burnett	Improve our ability to recognise and learn from the good practice within the team by reporting on it. Aim to establish a reporting structure which allows to highlight exapmples of good practice, share them with the person and share common theses with the wider team.	We will receive 30 reports over the 30 days.

Team Name	Main Contact	Project Aim	Measure
30 days of DASA	Lindsay Tulloch	All RMOs to register to be able to use Tableau; All disciplines to discuss the role of DASA and identify any gaps; Prepare Iona 2 to go live with DASA	Tableau into CTM's; pre, during and post access to Tableau; MDT member identified the role and use of DASA within their professional groups and provide feedback on findings; DASA rolled out within Iona 2; actino plan with Nursing Practice Development for DASA in Nursing Care Planning Guidance; action plan with Senior PMVA Instructor for DASA during new staff induction; improved completion rate of DASA assessments across the site.
The Clear Out Sisters	Ann Morton	A less cluttered office environment within 30 days	Improvement will be visual: pridein our working environment as it will be more organised and decluttered. Additionally reducing clutter on top of the filing cabinets and on the floor will make the room feel more open therefore the working environment will feel more warm and welcoming.
Formulate That	Aileen Burnett	Get patient's forumlation on RiO.	Every CPA held over 30 days, whichever Psychology team member is completing the Psychology Report will copy the existing forumlation onto the RiO template. 4 CPA's scheduled so the measurement will be how many of them have a formulation entered into RiO.
Psychology Admin for Efficiency	Lindsey McIntosh	We would like to reduce the amount of time it takes at the end of the month for the psychology secretaries to confirm that all relevant KPIs have been completed, returned, and the data entered onto other systems, where required.	At both Oct and Nov 2018 month end we will record the amount of time spent on processing KPI forms. We will compare the amount of time it takes in both months to determine whether we have met our goal of increased efficiency
C Line	Kim McLelland	Promote physically health and increase the physical activity for our patients. We aim to ensure patients have access to the appropriate levels of outdoor exercise and fresh air by providing a walking group on a daily basis	be measured by an increase in patient’s motivation, stamina as well as an increase in their mood
Mull-ti Disciplinary Working	Josie Clark	To strengthen communication and resource planning amongst the MDT and to make better use of our resources through more efficient service planning.	By making space at the start of the weekly CTM's to discuss what outings, visits, activities etc are coming un that week and check who could be available or who might be able to alter their diaries in order to support the likelihood of the activity going ahead.

Team Name	Main Contact	Project Aim	Measure
Peaky B-Linders	Zenzo Dube	Reduce the amount of telephone contact to improve quality time spent with patients on the ward.	Increased staff to patient engagement with patients on ward; increased face to face informal contact with wider MDT; increased informal contact with MDT and patient to arrange appointment times; carrying out everyday tasks in a more timely manner; spending more time with patients in the day area.
Open All Hours	Nicola Porter/Catherine Totten	Improved frequency of opening the hub for activities by various disciplines.	Comparison of hub opening frequency between October and November 2018
Woodwork to "do some work"	Pam Johnstone	The old Woodwork room has been cleared out ready for use but has not yet been organised for storage and no groups have used the room yet. We would aim to be able to have all the disability aids that are currently all over the hospital stored in this room, with an inventory and process for booking out this equipment. We also have arts/crafts materials in different hubs, so plan to have a joint store for this to help with stock rotation, better availability of materials and wider variety of materials that can be used by any Occupational Therapy staff. Another aspect of this project is, to start using the room for specific groups. The participate group is due to start shortly and we aim to use this room for that group.	We will know there is an improvement when there is a cupboard with all the ADL equipment, an inventory and booking in/out procedure in place. This will also be the case regarding arts/crafts materials and the latest craft materials order will be stored in this cupboard so there is access for all OT staff.
Cloza-team	Lynn Easton	We want to reduce the number of Datix entries around clozapine named patient dispensing on Iona 1	We will complete a baseline measurement of named patient clozapine per individual patients on Iona 1. Complete spot checks 3 times per week to record findings. Report on findings after 30 days.
The PLT	Rebecca Hart	The overall aim of the project is to increase awareness of the new CD and DVD resources that are available in the Patient Library.	When the posters are being created and other preparatory work completed the PLT will note the number of patients who visit and browse the resources in the library. This will be done by a simple tally mark system. Once posters and other marketing activities have been undertaken then another period of noting the number of patients who visit and browse the resources in the library will be completed. The numbers will be compared pre and post marketing to determine if any improvement has been made.

Team Name	Main Contact	Project Aim	Measure
Events Team	Sarah Innes	To improve patient participation in planning events in Arran hub by offering opportunities to participate in a voluntary role as an events committee member.	Patients who attend the events committee will report their views in a qualitative manner at the start of the meetings and again following the party. This will allow us to evaluate any changes in their level of participation and their views on the impact it had on them.
#teamselfie	Susan Brown	We would like to offer patients the opportunity to self report on their day. Our aim is to improve patient engagement, reflection, wellbeing and functioning leading to greater self-awareness.	CORE 10 pre and post; Uptake; Staff and patient views pre and post
PANSS People	Sheila Howitt	PANSS completion across the hospital appeared to be inconsistent our team have identified a number of possible barriers to these being completed. In TSH3030 we aim to improve completion of the PANSS forms in Arran , including the keyworker collateral information sheet.	Reviewing PANSS form completion for Arran CPAs in November looking at number of completed forms, if collateral information was provided and transcription of the information to the CPA document in time for the meeting.
Project Iona	Michelle McKinlay	The aim of the nursing staff in Iona 1 & 3 is to set a protected 30 minutes each day for dedicated patient care which will not be interrupted by administration tasks. By protecting this time, staff will have the opportunity to spend time with the patient group to provide meaningful engagement, activities etc.	Staff will record whether the specified 30 minute time period was protected and what activities took place.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	29 November 2018
Agenda Reference:	Item No: 11
Sponsoring Director:	Human Resources Director, Interim
Author(s):	Human Resources Director, Interim
Title of Report:	Attendance Management Improvement Working Group
Purpose of Report:	For noting

1 SITUATION

There have been significant sickness absence pressures within the Hospital, consequently the Improvement Working Group has been re-established.

2 BACKGROUND

The group re-convened in August 2018 due to the significant rise in sickness absence which was a matter of concern; placing pressure on the delivery of safe care as well as impacting on staff at work. The group continue to meet on a monthly basis working through the action plan attached.

3 ASSESSMENT

The attached action plan and includes four specific areas of work including;

- Leadership
- Training and Support
- Policy Compliance
- Agree and Monitor Outcomes

4 RECOMMENDATION

The Board is invited to:

- note the content the attached note and action plan from the October meeting.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives?	N/A
Workforce Implications	Considered in Section 3 of the report
Financial Implications	N/A
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)	No significant risks identified
Assessment of Impact on Stakeholder Experience	N/A
Equality Impact Assessment	N/A

The State Hospital

ATTENDANCE MANAGEMENT TASK GROUP MEETING **ACTION NOTES** **16 October 2018**

Chair: Jim Crichton

Present: Pamela Burnett; Jean Byrne; Moira Donoghue; Sandra Dunlop; Anne Gillan; Hazel Harrison; Brian Paterson; Pat McGlone; Paul McCormick; Linda McWilliams

In attendance: Rhona Preston

DRAFT - unable to approve - meeting not quorate 20 Nov 18

NO	TOPIC	NOTE /ACTION	LEAD
1	**Welcome and apologies**	Jim Crichton welcomed everyone to the meeting. Apologies noted from Kay Sandilands.	
2	**Action Notes of previous meeting**	JC confirmed he has already held engagement sessions at various times and various locations throughout the Hospital with staff from across the organisation. These sessions remain ongoing. These are proving worthwhile and an update on key issues will be provided at a future meeting.	**JC**
3	**Matters Arising**	No matters arising not already on the agenda.	
4	**Attendance Management Checklists and Reports**	Members received and noted the range of checklists to support the Attendance Management policy compliance. LMcW advised these forms are all available in the intranet, they are used currently in the 1-2-1 meetings with the HR Advisors either in their face to face meetings on weekly phone calls. The feedback to date has been very positive with Managers feeling very supported. PMcC confirmed he is supportive of this format and supports the signing off of the forms at the end of each meeting. HR are logging all meetings together with a log of all cancelled meetings. An end of year report will be presented to this group for information and action as appropriate.	**LMcW**

		HR are currently working with eHealth to compile calendar reports going back three years which would easily identify various patterns and specific dates. These are colour coded and are extremely visual by and will be a useful tool to support managers. It is hoped these will be ready to roll-out across the site during the HR Advisor meetings. JC explained to the group that at previous Partnership Forum meetings it was noted that support is given to staff in trying to assist and accommodate leave arrangements to help where we can with family pressures / school leave etc. There was discussion around staff who have been on either long-term or short-term sickness absence returning to their normal duties and then carrying out additional overtime duties. To support staff during their return to work members of the group agreed this requires to be addressed. PMcG advised of previous agreements that were in place where only staff who had returned to work for an agreed period would be rostered to work overtime shifts however many staff are returning and going straight onto overtime duties. BP advised members that a protocol for managing overtime following an episode of sickness absence will be presented to the next Operational Sub Group for approval. Compliance of this protocol will be the responsibility of Lead Nurses / Senior Charge Nurses.	
5	**Attendance Management Action Plan at 16 October 2018**	RP agreed to re-format to allow easier editing. 1.3 Staff Engagement, 1.3.1 – Focus Groups. SDunlop will email members of this group asking for assistance and support to facilitate these groups. PMcC asked about a previous discussion he had with Elaine Anderson relating to members of staff who are absent and cannot return to their contracted position however they could return to carry out alternative duties for a period of time until fit to resume to their own post. This had been done previously and resulted in a few issues being raised that would require to be worked through. Although the organisation are happy to encourage and support it would require further work to ensure it would be of benefit to all concerned, timeframes would need to be built into this, consistency across the site would need enforced and it would require close monitoring. PMcG asked for clarification on the contingencies that are in place should staffing in HR diminish again due to support being crucial in taking this work forward. JC and LMcW confirmed that support is in place due to the hospital having a flexible SLA arrangement in place with NHS Lanarkshire. A communication will be issued following the staff engagement sessions. 2.2.4 – SD to pick up with JC to ensure Meridian are not duplicating. 3.1.1 – It was noted that it is the responsibility of the Managers to ensure information is uploaded onto SSTS and not HR.	**RP** **SD/ALL** **CMcC** **SD & JC**

DRAFT - unable to approve at meeting held on date 20 Nov 18

		JC asked if there was anything to add into the plan. With regards to supporting staff with stress, JC advised that he has reported to the Partnership Forum that the Occupational Health department will be contacted asking them to conduct a stress audit. Findings can be discussed at a future meeting. JB was asked to share the link of the Health Working Lives Action Plan available on the intranet. There may be areas within this that link closely to the work being carried out by this group. • Mindfulness Project • Free / Self help resources • R U Ok? The above initiatives to be discussed further at a future meeting.	**JB / RP** **ALL**
6	**Any other competent business**	No any other competent business.	
7	**Date and Time of Next Meeting**	**<u>Tuesday 20 November 2018 at 11.30am</u>** {directly after Partnership Forum}.	

DRAFT - unable to approve - meeting not quorate 20 Nov 18

The State Hospital – Attendance Management Action Plan - November 2018

Task Group Aim: Achieve a 3% reduction TSH in month sickness absence by March (ISD 1st to 30th June 2018 level 9.80%)

	Aim	Actions	Tasks	Key Outputs	Timescale for Completion	Led By	Monitoring Status	Progress
1	**Leadership:** Ensure full engagement of senior managers and staff on this improvement target.	1.1 All Directors to be informed of the improvement target and trajectory	1.1.1 Set and monitor baseline and trajectory for improvement 1.1.2 Agree each Directorate contribution to that target	ISD 1st -31st March 2019 level ≤ 6.80%	31.03.18	Attendance Management Task Group (AMTG)		**COMPLETE** **COMPLETE**
		1.2 CEO and HRD to meet with all Directors and HOS on a 2-monthly basis to review progress	1.2.1 Schedule Meetings for end Oct/Dec/Feb	Meeting schedule in place	30.09.18	CEO		**In Progress**
			1.2.2 Agree standard agenda for meetings and supporting information	Standard agenda in place		HRD		**COMPLETE**
		1.3 Staff Engagement	1.3.1 Conduct focus group with managers and staff to identify barriers to policy implementation and staff experience	Summary report of key issues	30.11.18	S Dunlop & L McWilliams, supported by J Byrne		**In Progress**
			1.3.2 Hold a series of all staff meetings to discuss impact of absence and staff ideas for improvement		Oct / Nov 18	J Crichton		**In Progress**

	Aim	Actions	Tasks	Key Outputs	Timescale for Completion	Led By	Monitoring Status	Progress
2	**Training & Support**	2.1 Ensure staff are well informed on sickness absence policy	2.1.1 Develop and complete Mandatory Learn-pro Attendance Management module	Module available	31.10.18	S Dunlop		Module currently under development On target to complete end of Oct 2018
		2.2 Support Line Managers to implement policy		100% completion by line managers	31.12.18	S Dunlop		**In Progress**
			2.1.2 Develop and issue communication to advise all staff of aims, actions and key messages	Communication agreed and issued	30.09.18	C McCarron		**COMPLETE**
			2.2.2 Develop and issue checklists for: • Managers • Return to Work Interviews (RtWI) • HR / Manager meetings	Checklists available	30.09.18	L McWilliams		**COMPLETE**
			2.2.3 Conduct monthly meetings btw managers / HR to review and support management of staff sickness – specifically EASY, RtUI, Sickness absence paperwork, staff trigger sickness absence policy	Monthly meetings programmes and attended; exceptions reported to AMTG monthly	Monthly from 01.09.18	L McWilliams		**COMPLETE**

	Aim	Actions	Tasks	Key Outputs	Timescale for Completion	Led By	Monitoring Status	Progress
			2.2.4 Develop and deliver session to support line managers in managing difficult conversations	Sessions available and advertised	31.10.18	S Dunlop		Session content currently being developed in consultation with HR and dates for delivery currently being scheduled
				50% attendance by line managers	31.01.19	S Dunlop		
			2.2.5 Provide information on historic sickness absence patterns for managers including: • Staff absence over 12 months • Highest number of days lost in last 3 years • Sick leave and overtime hours • Stages of absence • EASY compliance	4 reports provided from SSTS	31.10.18	NHS Lanarkshire		**COMPLETE**
				Reviewed and actioned at HR / Managers meetings	31.12.18	L McWilliams		

	Aim	Actions	Tasks	Key Outputs	Timescale for Completion	Led By	Monitoring Status	Progress
3	**Policy Compliance:** Achieve full compliance with implementation of TSH sickness absence policy	3.1 Monitor compliance	3.1.1 HR to file all paperwork / electronic files relating to absence within 2 week of receipt. This includes medical certificates, RtWI, OHS reports	Staff files up to date with information received	31.10.18	L McWilliams		
			3.1.2 HR to monitor and report on receipt of RtWI paper work	100% compliance with RtWI; exceptions reported to AMTG	Monthly from 30.09.18	L McWilliams		
			3.1.3 HR monitor recording of RtWI via SSTS	100% compliance with RtWI: exceptions reported to AMTG	Monthly from 30.09.18	L McWilliams NHS Lanarkshire report		
			3.1.4 HR monitor OHS referrals made for employees on Long Term Sickness (LTS)	100% compliance with OHS referral; exceptions reported to AMTG	Monthly from 30.09.18	L McWilliams		
			3.1.5 HR monitor management of staff hitting sickness absence trigger	100% compliance with management of staff hitting trigger; exceptions reported to AMTG	Monthly from 30.09.18	L McWilliams		

	Aim	Actions	Tasks	Key Outputs	Timescale for Completion	Led By	Monitoring Status	Progress
4	**Agree and monitor outcomes**	4.1	4.1.1 Agree desired outcomes	6.8% S/A by 31 March 2019 Increase in staff understanding of the policy and confidence in its application Increased management compliance with the policy	By 31/03/2019	Attendance Management Task Group (AMTG)		

Monitoring Status:

Definition	Cell Colour
Requires improvement to meet timescale for achievement	**Red**
Not yet achieved but on target to meet timescale	**Amber**
Achieved	**Green**

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	13 December 2018
Agenda Reference:	Item No: 12
Sponsoring Director:	Human Resources Director, Interim
Author(s):	Organisational Development Manager
Title of Report:	Chief Executive Staff Engagement Sessions Report November 2018
Purpose of Report	For noting

1 SITUATION

At a meeting of the Attendance Management Group, it was agreed that a series of Chief Executive led staff engagement sessions would take place to share information about current challenges within the service including staff absence and to engage with staff regarding their ideas and suggestions for change. The focus would be on empowering staff to influence the direction and effectiveness of the organisation in tackling these key issues and for management to respond to those ideas. The report summarises the findings from those meetings with staff and makes some recommendations based on the conversations.

2 BACKGROUND

Since the opening of the new hospital in 2011/12, the service has seen a continuous rise in staff absence rates. The average annual rate of absence has risen from 4.54% (below the national average) to 8.52% in 2017/18. A range of initiatives have been undertaken to support and improve attendance at work, including same day support through EASY, a dedicated Occupational Health Service, and a Gold Standard Healthy Working Lives programme. Despite these initiatives, we have not seen the impact that we need to ensure that our service is delivered on a sustainable basis.

The impact of high staff absence is across the service. It is evident in lower staff morale, impacts on continuity of care and our ability to manage patient activities.

In addition to absence, the service has seen a significant rise in the numbers of staff associated with patient observation. A number of factors could be influencing this and anecdotal feedback has been in relation to the complexity of patients' care needs, higher incidence of physical health issues requiring offsite care, the impact of the new environment in nursing patients safely etc.

Several elements of work are in train to review these issues including an in-depth review of safety issues as they relate to patient on staff assaults; a review of our care delivery arrangements to ensure these continue to appropriately meet the needs of our patients; and a review of our staff rostering and shift arrangements to ensure the most effective deployment of our nursing workforce.

The importance of communication is well documented as a means of engaging staff. A series of Chief Executive led staff engagement sessions was planned and delivered over October and November 2018 to share information regarding these challenges and seek staff support and ideas on addressing them.

3 ASSESSMENT

Staff engagement sessions

Twelve meetings took place over October and November 2018 covering a total of 138 staff. The staff who attended represented a number of different areas in the hospital.

Staff Group	Number Attended		Staff Group	Number Attended
AHP	3		Nursing	57
Clinical Effectivness	2		PCIT	2
Consultants	2		Pharmacy	4
CP&BS	1		Psychology	4
Estates	10		Risk Management	1
Finance	3		Security	3
Housekeeping	18		Skye Centre Staff	19
L&D / OD	7		Social Work	2

General mood of sessions

Overall the sessions were generally well received. There were a number of very detailed and creative sessions with smaller groups of staff keen to understand the issues and bring forward ideas for improvement. The larger staff meetings were helpful to share information but felt less solution focussed. Some staff later reported that they felt less able to contribute in a large group of colleagues. This is a factor for consideration in future engagement sessions.

A number of staff made positive comments about the working environment and the benefits for both staff and patients:

- Commended the rolling recruitment programme for nursing staff.
- Acknowledged that NHS staff benefit from very generous absence support arrangements both in terms of support and protection of pay and enhancements.
- Encouraged by the current focus on quality improvement and the number of staff engaged in the 30:30 improvement programme. One person felt that this work had resulted in a community feel in the hospital.
- Agreed that Skye Centre activities are very positive for patients and staff. Wanted more opportunities for activities and social events.

However, there were also many concerns and all sessions provided a forum for staff's ideas and challenges. Notes were taken from each meeting and the feedback from the sessions is summarised below.

Staff absence

Message: Need to improve consistent application of the policy by managers.

Concerns

- More formal approach to absence needed to curb absence. In a small service, some managers may find it difficult to be impartial.
- Are we looking at trends in sickness absence over time.
- Not appropriate for staff to come back from sick leave and immediately do overtime.
- Some staff felt that others were abusing the policy and were unhappy when they always show up for work but others take 6 months off on paid leave.
- Need for greater flexibility with shifts – question around whether clinical staff should be required to plan annual leave one year in advance.
- Negative impact on staff teams of regular staff moves.
- Question about impact of ageing workforce on sickness absence.
- Staff supporting each other in terms of not doing overtime even when they would like to
- Staff taking time off because don't feel valued.
- Policy is structured in such a way that it is too easy to stay off.
- Overtime has become a way of life for some staff.
- Rosters not being kept up-to-date.
- Staff not getting to do their own jobs, not knowing what you will be doing or where you will be going – very unsettling.
- "I've lost specialist educational professionalism since I started working in the hospital due to being moved to staff the wards and not doing the job I'm employed for."
- Estates Team can't always access the wards when nursing staff are not available.
- Charge Nurse structure appears to impact on numbers on the shop floor.
- Want more input from other disciplines to help with staff shortages on wards.
- Consider use of Bradford Score to measure absence.

Things to try:

Message: Much greater emphasis needed on positive reinforcement of attendance.

- Make more use of data to analyse trends over time.
- Attendance management policy – explore managers' use of this. Identify resistance or obstacles to implementation of policy and address this.
- Let's look at how other High Secure hospitals (NHS England) manage rostering and see where we can improve. Look at Rampton model. What about our earlier centralized system?
- What is the baseline for staffing to cover rotas?
- Nursing Admin was helpful in its time. Can this be re-instated?
- Having staff with the right skills in the right place e.g. Admissions Ward, leaving other staff to get on with other patients.
- Review how policy is structured.
- Recruitment timescales in Housekeeping seem too slow. Do they need to change?
- Provide dedicated staff to manage sickness absence so that the EASY process is completed correctly and consistently. This already happens in Psychology Dept.
- Provide family-friendly shifts and flexibility when requested; also more control over rostering at ward level; booking of annual leave for clinical staff.
- Don't let people who have recently returned from sick leave to do overtime.
- Fears that new shift system will increase absence.
- Pre-booking of overtime rather than at last minute.

Staff recognition: 'I feel appreciated for the work I do'

Message: we need to do more to ensure staff feel valued at work. For some this was about their immediate manager, for others about Executives and the Board.

- Let staff know when the hospital receives recognition for its good work.
- Recognise when staff have done well by saying 'thank you' or 'well done'
- Recognise good attendance in some tangible way - letters of acknowledgement or other rewards; attendance allowance for staff (meal vouchers, club)
- Feeling that staff are not valued.
- Lack of valuing results in some staff feeling stressed and some taking time off
- Would support a staff awards scheme for the hospital to recognise good work.

Communication

Message: we are a small hospital and rumours spread quickly. More opportunities for face to face communication would help address this.

- Give staff up-to-date information on what is happening i.e. what Meridian is doing, even if there is nothing to report; rumours about job cuts as a result of Meridian's work; what our relationship with NHS Lanarkshire is and how this will impact the future; whether we require any further emergency savings plan or not; any plans for non-nursing staff to supplement numbers; how long this will go on for.
- Feedback regarding face to face session generally positive.

Managerial/work structures and procedures

Message: Need for greater empowerment of decision making at ward / dept level. Reduce admin burden on Senior Charge Nurses.

- Wards and hubs are not working in the same ways. Difficult and stressful when staff are moving wards/hubs. Needs direction from top down
- Band 5s filling in for Band 3s and getting paid at Band 5 rate for Band 3 overtime. Example of consultants not paid to be on a call.
- Changes to nurse management structure have not worked as intended. Often difficult to access a Charge Nurse or Senior Charge Nurse on a ward.
- Empower SCNs to make decisions and run their wards. Not needing to take everything to the clinical team. Medical staff are currently making clinical decisions.
- Stop using SRKs so frequently. Don't make this mandatory training. Staff don't want this. It has crept into practise where as previously used only for escorts.
- Investigations taking too long and insufficient communication about progress
- Stop adding things to our workload.
- Non-ward based level two staff not working to clinical principles or providing enough support.
- There are issues with CNs having to deal with absence phone calls as well as other duties.
- Do we need to re-introduce Nursing Admin?

Staff morale

Message: staff morale is low. Need to improve staff experience of work and ensure social element is supported.

- Feels less safe than before. May be to do with the new ward layout and more complex patients.
- Feeling that we are 'going back the way'
- Not as much laughter now.
- Fewer opportunities for staff to come together e.g. in the evenings or at weekends with patients for social events.
- Provide Healthy Working Lives initiatives in a more ward-accessible manner.

- Feeling helpless as not enough resources.
- Consider further support for staff to cope with stress.
- Impact on personal development due to staff shortages
- More complex needs of patients requires extra resource, is more demanding
- Appears to be less caring in the new hospital.

Staff development: 'I am given the time and resources to support my learning growth'

Message: staff development and opportunities is key to good morale.

- Training and development of Charge Nurses is 'not quite right'
- Consider how nursing assistant role could better support the registered nurse role, as is the case in acute settings.
- Have more confidence in staff and give more support and autonomy.
- Where a supervisor is absent, encourage others to fill the gap to gain experience.
- Housekeeping staff would appreciate opportunity to work in nursing pool with appropriate training and support; also more access to computers.
- Must nurture and develop younger staff with eye to the future.
- Share the learning from practice in different wards across the hospital.
- Embed Clinical Supervision more effectively.

Patient experience

Message: access to meaningful patient activity is a priority of patients and staff.

- Staffing in Skye Centre is an issue. Patients are not getting enough stimulus as staff are having to work on wards and so they are missing out on sessions. They are becoming disengaged and really upset.
- Patients don't like being mixed in with less well and newly admitted patients.
- More patients from prison and different mix of patients. Hospital is working with 'difficult to reach' patients (as we have lost medium and low secure patients).
- Space in wards: patients are sometimes having to eat in separate rooms, in telephone room because of lack of resource. Also they are sometimes no side rooms available for PTS treatment.
- More frequent ward closures than in the past means less quality patient care
- Patients feel they have no normalisation activities to do e.g. jobs, gardening, cleaning their rooms. Staff feel it is more like babysitting at times.
- Reintroduce an Admissions Ward.
- Consider evening activities for patients with support of OTs – will require a look at staffing. Could run a test of change for this.
- Teach patients more of the type of skills they will need in the future.
- Review what activities are on offer in the Skye Centre
- Consider running evening activities in Skye Centre with help from OTs. However, needs ward staff too.

Clinical model

Message: we need to review our approach to care delivery to ensure that we are best able to meet patient's needs as they progress through their pathway of care.

- Several calls for fewer admission wards to improve patient mix and allow staff skills to be developed.
- We are too risk averse to test anything out.
- Does rule of minimum 3 staff stop many activities from happening?
- Reinitiate the Recovery Model – would get more input from non-ward based clinical staff.
- Separate the Hubs into specific functions e.g. admission hub, long term care hub, rehab hub.

4 RECOMMENDATIONS

The Board is invited to note the following recommendations which to be made to the Senior Management Team.

1. Staff recognition
   Implement the staff recognition scheme immediately on successful completion of TSH 30:30 project currently underway. Healthy Working Lives could play a role in the scheme in terms of promoting positivity and a positive working environment.
2. Continue to keep staff well informed
   While we acknowledge that we have excellent communication coverage through our Staff Bulletin and Vision, our quality face-to-face communication must continue improve i.e. manager/supervisor to team, team meetings, engagement sessions. Good communication will help address the impact of rumours and will allow staff to feel they are involved in decisions that affect them.
3. Address inconsistencies in ways of working between hubs and wards to ease some of the stress experienced by staff who move about.
4. Work at empowering our managers more and being more willing to try things out. This would result in higher morale, a greater sense of ownership and dignity, faster and more effective decision-making and higher performance.
5. Grab opportunities to develop more junior staff when the occasion arises e.g. if supervisor is absent, encourage someone to act up; consider how nursing assistant role could better support the registered nurse role.
6. Patient experience: Explore staff suggestions to improve patient experience - many staff are concerned about the impact of current challenges on patients. Part of the hospital's mission statement is to provide high quality treatment and rehabilitation for patients.
7. Staff absence: Test ideas, where feasible, put forward by staff to ease the burden of staff absence.
   - Allow staff to work in other areas of the hospital for a time-limited period to rehabilitate them. Keep database of opportunities.
   - Issue clear communication to staff around 'fit notes' i.e. you can return to work before the last day.
   - Consider role of OH in liaising with GP service re sick lines.
   - Make our approach more appreciative, supportive and individualised e.g. recognising good attendance, not putting staff on stages if they have been assaulted.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Supports the ongoing work on attendance management
Workforce Implications	Time to implement ideas.
Financial Implications	N/A
Route to Board Which groups were involved in contributing to the paper and recommendations.	SMT/ Partnership Forum
Risk Assessment (Outline any significant risks and associated mitigation)	
Assessment of Impact on Patient Experience	It is well evidenced that good staff engagement is directly linked to a more positive patient and staff experience
Equality Impact Assessment	EIA Screened – no identified implications.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	13 December 2018
Agenda Reference:	Item No: 13
Sponsoring Director:	Human Resources Director, Interim
Author(s):	Training & Professional Development Manager & PMVA Advisor
Title of Report:	International Training Proposal
Purpose of Report:	For Approval

1 SITUATION

This report is seeking Board approval for a proposal to deliver PMVA instructor training in the United Arab Emirates (UAE), and for the international travel associated with this activity.

2 BACKGROUND

Following a visit to the State Hospital by representatives from the UAE Ministry of Health and Prevention, a request was received by the PMVA Advisor (Lynn Clarke) asking the State Hospital to deliver Level 2 PMVA instructor training for a group of nursing staff within Al Amal Psychiatric Hospital in Dubai.

PMVA instructor courses have previously been delivered by the State Hospital to a number of external organisations and provide an opportunity to share best practice, extend professional networks, and generate additional income. This, however, is the first time that training of this nature has been requested from an organisation from overseas.

3 ASSESSMENT

The proposal is for delivery of a 10-day Level 2 PMVA training/instructor course for up to 12 delegates. The training will be delivered within Al Amal Hospital in Dubai by 4 PMVA instructors from the State Hospital, in collaboration with Mark Robinson, Head of Education and Development at AL Amal Hospital. Mark is a qualified PMVA instructor and, in addition to his role within the Ministry of Health & Prevention in the UAE, is an Honorary Principal Lecturer/Curriculum Consultant at the University of Sunderland, and a Visiting Lecturer and External Examiner for mental health and forensic programmes at the University of West of Scotland

A copy of the full training proposal is attached for information in Appendix 1. Provisional dates have been identified for late January 2019 and discussions have taken place with the Clinical Operations Manager regarding release and backfill for 2 PMVA instructors who work within front-line nursing roles for the 2-week period required. (The additional 2 PMVA instructors work within practice development and corporate training and replacement cover during their absence would not, therefore, be required.)

All costs associated with delivery of this training will be met in full by the UAE Ministry of Health and Prevention. This includes the salary costs for all 4 instructors, plus all travel and accommodation expenses. The total agreed cost includes an 'add-on' fee to support income generation, with a projected income, once salary costs are deducted, of approximately £6000.

The Government's foreign travel advice website has been reviewed to ascertain the risk level for staff travelling to the United Arab Emirates. There are currently no safety or security alerts advising against travel to the UAE, and no significant risk factors have been identified that would make it inappropriate for State Hospital staff to travel to the UAE to deliver the proposed PMVA training.

Confirmation has been sought from the CNORIS Manager in NHS National Shared Services regarding travel insurance and indemnity cover for any liabilities associated with the proposed training delivery (e.g. in the event of illness or an untoward event involving a staff member during the trip or training delivery; if a participant is injured during training and any associated injury compensation claims, etc). We are currently still awaiting their response.

4 RECOMMENDATIONS

Subject to confirmation of adequate travel and indemnity insurance cover arrangements, the Board is asked to **approve** this request.

APPENDIX 1

PMVA TRAINING AGREEMENT

COMBINED PMVA LEVEL 2 & PMVA INSTRUCTOR TRAINING COURSE
(Duration - 10 Days)

Training Dates

Detailed below is the final agreement for delivery of Level 2 Prevention and Management of Violence and Aggression (PMVA) Training and associated PMVA Instructor Training.

Level 2 PMVA and Train the Trainer programme will be delivered by 4 instructors from the 27January to 7 February 2019.

As agreed, the instructors will arrive on Friday 25 January (with an orientation to Al Amal Hospital on Saturday 26 January 2019), and depart on Friday 8 February.

Cost

The cost for delivery of a 10-day course for up to 12 participants is detailed below:

- *Course delivery fee - £17200*
- *Course materials and administration costs - £300*
  Total cost £17500

The payment invoice will be raised through Maudsley Health/Macani Medical Centre (which is part of the NHS South London and Maudsley NHS Foundation Trust). The requirement for the invoice to be raised through a third party is for payment to be made in sterling to the State Hospital.

Please note that travel and accommodation costs (x 4 instructors) have not been included in the costs provided above. These costs would be in addition to the above total and will be met in full by the Ministry of Health and Prevention, UAE.

Overview

This course aims to equip staff with the essential knowledge and skills required to proactively and safely manage violence and aggression. In addition participants will gain the confidence required to effectively and competently deliver PMVA training at Level 1 and Level 2.

The course explores the causes of violence and aggression within the mental health environment and strategies for reducing challenging behaviours, de-escalation techniques for managing a situation once it has escalated, dynamic risk assessment principles to help staff recognise the appropriate course of action, and the law regarding use of physical force. It also teaches staff physical intervention techniques including disengagement and defence techniques, basic guiding and holding, and restraint techniques for varying risk levels and situations.

The training is based on a proactive and person centred approach to managing conflict and emphasises the use of physical intervention and restraint as a last resort.

Course content

The course will include input on the following:

- Scale of violence and aggression
- Models of aggression
- Common triggers for violence & aggression
- Escalation and warning signs of imminent violence
- The assault cycle
- De-escalation and conflict resolution
- The law relating to the use of physical force
- Postural asphyxia
- Basic life support
- Physical intervention principles and techniques (including breakaway techniques, non-secure and secure holds, and team restrain)
- Incident review, recording and staff support
- Role and responsibilities of the PMVA instructor
- PMVA instructor standards and code of practice
- Maintaining participant health and safety
- Training cycle and learning styles
- Teaching plans and presentation delivery
- Hierarchy of responses
- Conflict management
- Use of force (including policy, legal considerations and guidance)

All participants must successfully complete the course assessment. The assessment methods used include observation and assessment of practical skills, an oral presentation, and a written assessment.

The physical intervention techniques taught on the course are based on a hierarchy of responses and include:

Breakaway techniques
- Protective stance
- Release from wrist grabs
- Release from clothing grabs
- Release from hair grabs
- Release from strangles
- Release from bear hugs

- Release from bites
- Defence against punches and kicks

Restraint techniques:
- Secure and non-secure holds (i.e wrist lock, straight arm hold, figure of 4 hold)
- Achieving secure holds from a standing position
- Achieving secure holds from a lying position
- Turning patients on the ground
- Standing and relocating patients (including negotiating doorways and stairs)
- Seated de-escalation
- Interchanging roles
- Separating patients fighting
- Leg controls

Learning objectives

By the end of the course participants will be able to:

- Define the terms 'violence and aggression'.
- Describe the scale of the problem.
- Discuss legal and ethical issues associated with the management of violence and aggression.
- Demonstrate an understanding of the relevant legal framework, policy and procedural context.
- Understand the nature and hazard of violence in the workplace.
- Explain models and types of aggression
- Identify trigger factors which can lead to a violent and/or aggressive incident.
- Discuss communication skills which can be used to help de-escalate a potentially aggressive and/or violent situation.
- Demonstrate the practical application of PMVA techniques.
- Identify signs and symptoms of postural asphyxia.
- Undertake basic/intermediate life support procedures
- Recognise the potential impact of exposure to aggression and violence and be aware of the role and sources of support.
- Understand responsibilities for reporting incidents.
- Understand the importance of conducting post incident reviews.
- Understand and how to use different teaching techniques
- Plan and deliver interesting and effective PMVA training sessions
- Know how to teach confidently and effectively
- Assess how well participants are learning

Course pre-requisite requirements

All participants are required to undergo health screening prior to undertaking this course. This includes a pre-course self-assessment plus completion of a Health Declaration on the day of the course which will be assessed by the course tutors.

This course is suitable to learners of varying fitness levels however given the physical nature of the training we cannot accept pregnant participants on the course.

To ensure participant safety and comfort during instruction it is essential that learners are suitably attired for this course. Failure to do so may mean refusal to participate on the course. Key requirements are outlined in the guidance below:

- No hard soled shoes, boots, hiking boots or steel toe-capped footwear should be worn. Ideally it is recommended that trainers are worn.
- No jeans to be worn. Ideally it is recommended that tracksuit bottoms are worn.
- No items of clothing should be worn with studs, decorative zips or embellishments such as beads, sequins for example.
- No belts with buckles are to be worn.
- All jewellery (including body piercings) to be removed. Where items cannot be removed they should be secured in place with tape.

Additional information

Participants will be trained to the standards set out in the 'Positive and Safe Violence Reduction and Management Programme Instructor Manual' developed by the high secure hospitals in England and Scotland. The manual has been endorsed by the National Institute for Health and Care Excellence (NICE) in their guidelines on violence and aggression (NG10).

Completion certificates will be issued to all delegates on successful completion of the course.

Each participant will receive a PMVA Instructor Training Manual.

Following completion of the training it is recommended that instructors undertake an annual update to maintain their competence and skills.

Disclaimer

Following attendance and completion of any PMVA training delivered by the State Hospital, the sole responsibility for ensuring staff adherence to approved PMVA techniques (i.e. the techniques that are taught on PMVA training) lies with the relevant employing organisation.

The State Hospital shall not be held liable for any variations or adaptations made to techniques taught on PMVA training, or for any injury sustained by patients or staff during the application of PMVA techniques.

In addition, the State Hospital will not be liable to you or other affected parties for any injuries or associated legal claims resulting from injuries sustained by participants on PMVA training delivered by PMVA instructors not directly employed by the State Hospital.

Contact details of the provider

Prepared By: Lynn Clarke

Date of Issue: 08 August 2018

For and on Behalf of: NHS State Hospitals Board for Scotland

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MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Ensuring organisational compliance with legislative requirements relating to the organisation's duty of care for the health, safety and welfare of staff. Monitoring of staff requests for International Travel related to sharing of best practice, training and development.
Workforce Implications	Covered within Section 3
Financial Implications	Covered within Section 3
Route To Board Which groups were involved in contributing to the paper and recommendations.	Interim Human Resources Director
Risk Assessment (Outline any significant risks and associated mitigation)	Covered within Section 3
Assessment of Impact on Patient Experience	Any learning will be shared across the organisation for the benefit of patient care.
Equality Impact Assessment	No issues

THE STATE HOSPITAL BOARD FOR SCOTLAND

Date of Meeting:	13 December 2018
Agenda Reference:	Item No 15
Sponsoring Director:	Director of Finance and Performance Management
Author(s):	Head of Management Accounts
Title of Report:	Financial Position as at 30 November 2018
Purpose of Report:	Update on current financial position

1 SITUATION

1.1 The Senior Team and the Board consider the Revenue and Capital plans, and financial monitoring. This report provides information on the financial performance to 30 November 2018, which is also included in the Partnership Forum agenda.

1.2 Scottish Government requested a 1 Year Operational Plan (this was narrative only – with a financial template forecast submitted for a 3-year period). This was approved by the April 2018 Board Meeting. (The format had changed from previous years' Local Delivery Plans that covered 3-5 Years).

1.3 This Plan sets out a balanced budget for 2018/19 based on achieving £1.484m efficiency savings, as referred to in the table in section 4.
Recognition of recurring posts, saved through recent workforce reviews, and utilities efficiency savings, amounting to £0.280m have already been realised in the 2018/19 base budget. In effect, that brings the total savings target to £1.765m.

2 BACKGROUND

2.1 Revenue Resource Limit Outturn

The annual budget of £35.708m is the Scottish Government Revenue Resource Limit / allocation and anticipated monies.

The Board is reporting an over spend position of £0.289m to 30 November 2018, with the in-month movement an under spend of £0.163m, primarily due to:-

- Pay Award now offset with savings, the savings figure was set before we had confirmation we were to receive the additional pay award monies. The benefit this month is £0.077m.
- We have assumed tranche 2 hand back will not happen, benefit this month of £0.044k.
- Corrections for last month's accruals £0.035m.
- Nursing overtime down by £0.014m.

2.2 Forecast Outturn

The forecast outturn trajectory to date was £0.150m of overspend, however the YTD position is £0.289m overspent, therefore the current position is an adverse variance of £0.139m.

The other area of positive movement may be if HMRC settle in our favour to reduce VAT on utilities to 5% from 20%, but given the uncertainty, this has not been anticipated, but noted in the table at 2.3.

Given the present position against the forecast trajectory, principally arising around Nursing overtime levels, we are currently identifying actions and measures to be addressed in order to alleviate these pressures in the remaining months of the year, and to enable the financial forecast to maintain a breakeven position for March 2019. While these pressures remain, and until the outcomes of actions identified by our Sustainability Task Group are known to be effective, we will not be in a position to contribute the second £0.220m to the National Boards savings, as that would adversely affect our ability to achieve breakeven for 2018/19, this has now been reflected in November accounts.

We will of course monitor the forecast outturn monthly during November 2018 – March 2019, and should the position improve sufficiently then we will be able to readdress this with the National Boards.

YTD Overspend prior year YTD Nov '17				(169,029.17)
3AN - Level 3 Account Name	Annual Budget £'s	Year to Date Budget £'s	Year to date Actuals £'s	YTD Variance (budget less actuals) for period 8
Other Operating Income	(589,051.00)	(392,700.66)	(645,650.63)	252,949.97
Pay	28,859,676.14	18,981,933.52	19,594,400.66	(612,467.14)
Savings	(292,325.17)	(67,213.86)	0.00	(67,213.86)
Purchase Of Healthcare	820,585.00	547,056.66	544,930.76	2,125.90
Non Pay	4,940,018.00	2,979,290.57	2,931,848.79	47,441.78
Hch Income	(790,537.00)	(527,024.68)	(625,050.30)	98,025.62
Capital Charges	2,760,123.00	1,840,082.00	1,850,395.10	(10,313.10)
	35,708,488.97	**23,361,423.55**	**23,650,874.38**	**(289,450.83)**

2.3 The table below notes areas that should be brought to the attention of the Board – although at this stage they are unquantified, these have the potential to affect the year-end outturn.

PRESSURES
National Pay Deal (effect on ongoing overtime)
Holiday Pay (and possible retrospection)
Rebandings
Perimeter Fence - FBC - Additional Staff
Double Running costs for senior managers resilience
DOCAS (SLA for Union dues)
POSSIBLE BENEFITS
If VAT element on Utilities in our favour (v HMRC)

3 ASSESSMENT

YEAR TO DATE POSITION – BOARD FUNCTIONS

Directorates	Annual Budget 1819 £'k	YTD Budget Nov 18 £'k	YTD Actuals Nov 18 £'k	YTD Variance (budget - actual) (adverse) / favourable Nov 18 £'k	Budget wte	Actual WTE
Cap Charges	2,760	1,840	1,850	(10)	0.00	0.00
Central Reserves	554	(89)	14	(102)	0.00	0.00
Chief Exec	1,899	1,266	1,223	43	23.67	23.53
Finance	2,724	1,825	1,767	58	37.33	36.06
Human Resources Directorate	776	517	510	7	13.33	11.61
Medical	3,447	2,296	2,125	171	34.63	34.49
Misc Income	(130)	(87)	(72)	(14)	0.00	0.00
Nursing And Ahp's	18,154	12,103	12,616	(513)	378.82	386.90
Security And Facilities	5,524	3,689	3,619	70	123.63	113.84
Under / (over) spend	**35,708**	**23,361**	**23,651**	**(290)**	**611.41**	**606.43**

3.1 **Capital Charges** updated forecasts suggest an annual pressure of around £0.018m.

3.2 **Central Reserves / unidentified savings** – the actual 'spend' is the accrual for the outstanding pay award (non-AFC). YTD credit budget is unidentified savings. Other monies sit centrally (phased to Month 12) until released to match appropriate spend.

3.3 **Chief Executive** –
HR Director secondment only being filled 0.50wte.
2/5ths of Finance Director to be recharged to Golden Jubilee.

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

3.4 **Finance –** benefit recognised from vacancy management, and research currently under spent.

3.5 **Human Resources** – some part time posts against full time establishment.

3.6 **Medical Services –** Recharges to other Boards are higher than was planned in base budgets, and benefit of earlier vacancies.
Psychology – vacancies have been held back due to ward closures.
Pharmacy – currently reflects an underspend on drugs.

3.7 **Miscellaneous Income** – this includes RHI Income, until released to match related spend in Estates.

3.8 **Nursing and AHPs**

Further detail has been provided, in table below, on this Directorate.

Nursing & AHP's	Annual Budget £'k	Year to Date Budget £'k	Year to date Actuals £'k	YTD Variance (budget less actuals) for period 08 Nov 18	Budget WTE	Actual WTE
Advocacy	147	98	98	0	0.00	0.00
AHP's & Dietetics & SLA'S	607	405	311	93	13.38	10.34
Hub & Cluster Admin & Clinical Operations	762	508	541	(33)	23.17	22.72
PCI & Pastoral	193	129	105	23	3.40	2.40
NPD & Infection Control & Clin Gov	386	258	259	(2)	5.80	5.53
Skye Centre	1,518	1,012	959	53	38.33	32.98
Ward Nursing	14,541	9,694	10,342	(648)	294.74	312.93
Total Nursing and AHP's	**18,154**	**12,103**	**12,616**	**(513)**	**378.82**	**386.90**

Advocacy – additional RRL now received from SG, therefore no issues.

AHP's (Dietetics and OT) – beneficial effect of vacancies.

Hub & Cluster Admin & Clinical Ops – excess due to costs of overtime and earlier double running.

PCI & Pastoral - beneficial effect of vacancies

NPD etc. – Seconded posts from Nursing.

Skye Centre – beneficial effect of vacancies**.**

Ward Nursing Overtime, detailed in table overleaf.

The £s/hours is for the previous month's overtime/excess, e.g. April pay relates to March hrs

The £'s includes NI'ers @ 11%

2018/19 Ward Nursing Hours		
Period	Overtime Hours	Excess Hours
APR	1,645	503
MAY	3,900	485
JUN	5,310	531
JUL	5,027	536
AUG	6,330	765
SEPT	6,781	665
OCT	4,838	479
NOV	4,347	322
TOTAL	**38,178**	**4,286**

The £'s includes NI'ers @ 11%

2017/18 Ward Nursing Hours		
Period	Overtime Hours	Excess Hours
APR	3,732	734
MAY	3,010	707
JUN	4,046	464
JUL	5,144	568
AUG	6,822	848
SEPT	6,885	496
OCT	6,694	552
NOV	6,587	377
TOTAL	**42,920**	**4,746**

2018/19 Ward Nursing £s		
Period	Overtime £	Excess £
APR	41,056	7,981
MAY	100,150	7,945
JUN	136,449	8,164
JUL	131,193	8,683
AUG	165,734	12,590
SEP	178,136	10,905
OCT	129,588	7,794
NOV	113,828	5,059
TOTAL	**996,134**	**69,121**

2017/18 Ward Nursing £s		
Period	Overtime £	Excess £
APR	93,077	11,283
MAY	75,198	10,553
JUN	100,626	7,136
JUL	130,226	8,526
AUG	174,100	12,473
SEPT	177,335	7,781
OCT	177,187	8,072
NOV	168,648	6,058
TOTAL	**1,096,397**	**71,882**

YTD Nov '18 A further £45k overtime is charged to Nursing from the Skye Centre

3.9 **Security and Facilities**

Security & Facilities	Annual Budget £'k	Year to Date Budget £'k	Year to date Actuals £'k	YTD Variance (budget less actuals) for period 08 Nov 18	Budget WTE	Actual WTE
Facilities	4,003	2,669	2,554	115	83.86	74.65
Security	1,521	1,020	1,065	(45)	39.77	39.19
Total Security & Facilities	**5,524**	**3,689**	**3,619**	**70**	**123.63**	**113.84**

Facilities – Utilities currently under spent mainly due to timing, underspends in Housekeeping and Hotel Services are due to ward closures and effect of staff savings.

Security – Mainly Backfill effect for sick cover.

4 EFFICIENCY SAVINGS TARGET

4.1 To balance the financial plan in 2018/19 the Board was required to release £1.765m of cash from budgets through efficiency savings. As noted in 1.3 above, £0.280m was recognised in the recurring base budgets, with £1.484m savings still to be realised in year.

4.2 The following table shows the annual savings, achieved to date, and still to be achieved in the remaining months.

The unidentified savings value has now been partly offset by the £0.300m revenue funding received September for pay awards, and the £0.220m tranche 2, as noted above.

The level of recurring savings realised to date is encouraging, although this will require continued focus.

Savings Annual Target LDP	Savings Annual Target LDP			Savings (Achieved) YTD, as at Nov 18			Savings still to be achieved by year end		
	2018-19 Rec £000s	Non-Rec £000s	Total £000s	2018-19 Rec £000s	Non-Rec £000s	Total £000s	2018-19 Rec £000s	Non-Rec £000s	Total £000s
Efficiency & Productivity Workstreams:									
Service redesign (Clinical)	5	0	5	0	0	0	5	0	5
Drugs & Prescribing	20	20	40	0	10	10	20	10	30
Workforce	244	588	832	270	588	858	-26	1	27
Procurement	0	0	0	0	0	0	0	0	0
Financial management / corporate initiatives (Non Clinical)	29	47	76	19	0	19	10	47	57
Financial management / corp init (Non Clinical) - Estates	133	65	198	82	20	102	51	45	96
Other	0	100	100	0	0	0	0	100	100
Unidentified Savings	0	515	515	0	483	483	0	32	32
Total In-Year Efficiency Savings	**431**	**1,334**	**1,765**	**371**	**1,101**	**1,472**	**60**	**232**	**292**
£280k already achieved in base	Trajectory (1/12ths of LDP)			**287**	**889**	**1,176**			
	(under) / over achieved			**83**	**212**	**296**			

5 CAPITAL RESOURCE LIMIT

Capital allocations anticipated from Scottish Government amount to £0.269m, which does not recognise any specific funding yet for the Perimeter Security Project.

	Annual Plan £'k	YTD Plan £'k	YTD Actual £'k	YTD Variance £'k
Estates	30	30	30	-
IM&T	30	28	28	-
Vehicles	-	-	-	-
Other equipment	209	19	19	-
Security Fence Dvpt	-	15	15	-
TOTAL	**269**	**92**	**92**	**-**

6 RECOMMENDATION

6.1 **Revenue: Over spend of £0.289m.**

Earlier unidentified savings have now been partially covered by the pay award allocation and assuming Tranche 2 not returned. The levels of nursing overtime spend are considered not to be sustainable through the remainder of 2018/19.

Quarterly Financial Review meetings, over and above the monthly Management Accounts meetings, help eliminate any surprises in the accounts and aids forecasting the year-end outturn. Savings are realised monthly and are now ahead of plan due to reflection of pay awards and tranche 2. Should anything materialise from HMRC around reducing VAT on utilities to 5% from 20% then we may be able to consider the tranche 2 handback.

We are putting plans in place now in order to achieve the projected year-end breakeven position.

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

6.2 **Capital: Budget is matched to year to date spend.**

A requirement for additional funding for Data Centre Replacement has been identified, which it has been indicated by SG may be addressed through the National Boards' group – this is to be discussed further. When this is confirmed, there will then be reprioritisation of other projects against the core capital budget.

At this stage, we predict utilising the full allocation with a year-end breakeven position.

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

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Monitoring of financial position
Workforce Implications	No workforce implications – for information only
Financial Implications	No financial implications – for information only
Route to Board Which groups were involved in contributing to the paper and recommendations?	Head of Management Accounts
Risk Assessment (Outline any significant risks and associated mitigation)	No significant risks identified
Assessment of Impact on Stakeholder Experience	None identified
Equality Impact Assessment	No identified implications

Board Paper 18/88

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	13 December 2018
Agenda Reference:	Item No: 16
Sponsoring Director:	Director of Nursing and AHPs
Author(s):	Director of Nursing and AHPs/Head of Corporate Planning
Title of Report:	Service Sustainability and Transformation Update
Purpose of Report:	For noting

1 SITUATION

At the October meeting of the Board, a paper was delivered on the actions agreed in pursuit of service sustainability. Over the past 4 months, good progress has been made in these areas and two distinct areas of focus remain:

- Achieving financial balance and enabling service sustainability
- Transformational change

The Service Sustainability Group continues to monitor actions and to generate ideas for further action that can be taken in pursuit of overall service sustainability. This paper updates on work completed to date on achieving financial balance and service sustainability, and offers an overview of work underway to achieve transformational change.

2 BACKGROUND

As previously reported to the Board, the end of the 17/18 financial year was challenging in that we required to implement a range of emergency recovery measures to achieve a near breakeven financial position. While these actions were successful, the short-term nature of the planning and delivery of this was undesirable.

In 18/19 we continue to be alert to emerging pressures in the budget, and have seen indications early in the financial year that assertive action was required to plan to achieve this, balancing financial performance with maintaining high quality care delivery.

The financial position at the end of month 8 is a reported overspend of £289,000. This compares to £253,000 for same period in 17/18. The pressure in nursing overtime remains, with a YTD spend of £996,000. This is £100,000 less than at the same point in 17/18. Overtime costs paid in November were £114,000 versus September, when they were £178,000 – a significant improvement realised through focus on overtime controls but still representing a significant cost pressure.

As previously reported to the Board, challenges have been experienced in achieving sustainable service delivery. Since the start of October, the requirement to implement business continuity measures has been more frequent, with 15 occasions when we have been unable to achieve safe staffing levels and have had to restrict care, including confining patients to their rooms. This affected 6 wards. This was compounded by a week of informal action taken by staff from 3 to 9

November in which no overtime was worked and affected normal service delivery. Wards were closed on 21 occasions during this period.

Ongoing engagement with our workforce will be key in achieving and sustaining change, and a series of CEO engagement sessions were delivered from Friday 12 October. 12 sessions were held, involving more than 100 staff.

3 ASSESSMENT

With regard to achieving financial balance and enabling service sustainability, multiple actions are being progressed. Where scope for a specific cost reduction has been identified, then this is detailed below. Where a cost reduction has not been identified, then these actions will broadly support the delivery of a more sustainable service.

Programme	Action	Impact	Status
Nursing pool	Recruitment of 10 x 0.6 WTE posts	Overtime off set of £13K per month.	7 staff in post and working in wards as of 3 December. Shift availability being well utilised, with just 15 hours not utilised out of 270 in first week.
Training delivery	Review to minimise staff release costs	Reduction of projected backfill costs of £50K	Agreed, with training programme adjusted.
9-5 staffing	Clinical teams to identify patient who may benefit from this approach. Policy change.	Reduces potential overtime costs by £6K per month.	Policy change implemented to support systematic consideration of 9-5 staffing. One patient identified and model in place.
Sickness absence	Establish task group. 0.5% reduction per month target.	£87K reduction in cost pressures associated with absence.	Task group formed. October absence 8.9%, which is a 1% reduction from July.
Target operating model in PTS	Scope for SLA's with other services	£35K income to April 2019 based on agreed SLAs.	In progress with high degree of confidence regarding delivery.
Non clinical workforce planning	Review of exec admin and finance workforce	Resources matched to service needs.	Finance review being progressed, admin to commence before ned of 2018.
SLA reviews	Review of Advocacy and Social Work SLAs	Any cost reductions will be clarified as part of SLA process.	Advocacy PIN issued. Open days completed and tender will be issued late January 2019.
Cross charging	Charging of £796 per day for 'exceptional circumstances' patients	Charges from 1 October 2018 for new exceptional circumstances admissions.	Implemented. No new exceptional circumstances
Vacancy management	Introduction of risk assessed approach to recruitment, and monitoring of recruitment timeframes.	Recruitment decisions informed by clinical need, efficiency, H&S, and capacity to meet targets. No delays in recruitment.	Close scrutiny of all vacancy requests via Directors and SMT. Working to a 12 week recruitment target.
Effective rostering	Review of nurse rostering to ensure leadership in	Fuller engagement with MDTs and other	Implemented.

	right place at right time.	functions such as HR	
Staff wellbeing	Tighten controls on overtime hours worked by nursing staff, limiting to 23 hours per week.	Improved controls. Reduced risk. Positive impact on health and wellbeing of staff.	Implemented with clear reduction in hours worked by staff and overtime spend. Significant progress made with only 3 > 100 hour OT events in November.
Programme	**Action**	**Impact**	**Status**
Improving observation practice	Roll out of clinical pause model Revision of policy and associated practice change	Ensuring resource is closely matched to meeting assessed need. Improved care experience Improved staff experience.	Clinical pause will be fully implemented by early 2019. 66 pauses completed to date. Policy review by end of financial year.
Patient active day	Extension of patient active day into Arran 2.	Reduced departmental closures in Skye Centre. Increased service resilience.	Project implemented 23 August. 3 month test of change due for evaluation.
Nursing Practice Development time in wards	20% of NPD time will be ward facing for full time staff	Increased support for ward nursing staff	Implemented.
Focus on MDT planning and delivery	Systematic approach to be in place in all hubs to ensure co-ordinated planning of activity.	Resources matched to meeting needs.	Progressed as part of the TSH3030 improvement programme.

With regard to service transformation, there are two key areas of work are being progressed:

- Meridian
- Review of the clinical service delivery model.

Meridian commenced work with The State Hospital on 26 October. A decision has since been made to refocus work on the review of our clinical care delivery, and to conclude our work with Meridian early. The last working day for Meridian was Friday 7 December.

With support provided through the Chief Nursing Officer's office, we will also focus on:

- Effective application of the nursing workload tools, common staffing method and roster management
- Robust analysis of reports and workforce information for the organisation
- Identification and/or development of approaches and strategies for effective risk assessment, mitigation, escalation and prioritisation of nursing workload and workforce planning concerns.

The second part of service transformation is focused on the review of the clinical service delivery 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.

Review of the clinical model principles
October 2018

A questionnaire was sent out to internal and external stakeholders to review the relevancy of the clinical model principles in October 2018. The Forensic Network Continuous Quality Improvement Framework Review in April 2018 highlighted the need to review these principles given that almost a decade has passed since their development.

A total of 12 forms were received during the consultation from the following:

- Patients x 1 (PPG where 14 patients were present)
- Staff x 7
- Carers x 2
- Volunteers x 1
- External (Mental Welfare Commission) x 1

All forms stated that 8 of the principles are still relevant. These were:

1. Integration
2. Patient-Focused Care
3. Individualised Care Pathways
4. Positive Therapeutic Milieu
5. Supporting Staff
7. Violence Risk Assessment and Management
8. Comprehensive Mental & Physical Health Care and Treatment
9. Clinical Governance Strengthens and Informs Care

One stakeholder feedback that principle number 6 'Strengthen Multi Disciplinary Working' should now be a 'given' expectation, and the principle wording adjusted to 'Multi Disciplinary Working' – although the overlap with principle 1, Integration, should be addressed.

From the feedback, the following conclusions were made:

- The principles are still as relevant today as they were when they were published.
- Minor rewording is required to a few.
- There is some duplication between Integration and Strengthen Multi Disciplinary Working that requires further discussion.
- Further principles about Carers/Named Persons and Security should be considered.
- Many of the comments received were about the delivery of the principles which will be addressed through a separate questionnaire.

Review of Safety Factors
Staff and Patient Safety Report August 2018

In August 2018 a review of the safety data within the State Hospital related to the delivery of clinical care was carried out to examine trends, where possible, over a 5 year period. The data reviewed included incident reports on violence and aggression and feedback from a staff survey.

The *key findings* within the report were as follows:

- There has been an increase in the number of incidents in the last 5 years however the trend was not linearly upward and numbers vary each year.
- The ID population has more incidents and assaults than the MMI population allowing for its size.

- There is a small number of patients who carry out assaults on staff, this varies and this number has not shown an increasing pattern. There are a very small number of patients (2-3 in 2017-18) who carry out the majority of assaults.
- Most assaults are in the rehabilitation patient cohort rather than admissions, even allowing for size of groups.
- There is an increasingly complex use of enhanced observation, seclusion and use of soft restraint kit with additional staff.
- No evidence was found to support the theory that TSH is dealing with more prisoners with antisocial behaviour who would carry out assaults.

Nine recommendations were contained within the report and are currently being implemented.

Review of the Clinical Service Delivery Model
December 2018

A review of the Clinical Service Delivery Model is progressing. This will take a staged approach with stage 1 being consultation with clinical staff on how we deliver clinical care. A questionnaire is currently live seeking the views of clinical staff on the following areas:

Clinical Care Questions

1. What are the strengths in the way we deliver our clinical care?
2. What are the current problems in the way we deliver our clinical care?
3. What changes would you make to improve the way we deliver our current clinical care?
4. What would we need to think about to enable your proposed changes to improve how we deliver our clinical care?
5. What else do you need to support you to deliver high quality clinical care?
6. Is there anything else you would like to say about how we deliver clinical care?

This questionnaire will remain live until beginning of January. Thematic analysis will be carried out and the results fed into stage 2, a workshop for staff to consider what the implications of the feedback from the questionnaire is for future service delivery.

This workshop will take place in early February and will result in the development of a range of options for change. These options will be appraised in terms of financial and workforce implications. Stage 3 of the process will be wider consultation and engagement of stakeholders through a stakeholder workshop to be held later in February / early March to consult on potential options.

From this approach any recommendations will be presented to the SMT and the Board with regard to any service change proposals.

Going forward, challenges remain as we look forward to the final quarter of the financial year. Where further adjustments may be required to current activities, these will be underpinned by the principles of no direct impact on patient care, and developed through engagement with staff side partners.

4 RECOMMENDATION

The Board is invited to **note** this update, and to request that an **update** on progress be delivered to the February 2019 meeting of the Board.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Supports delivery of OPD and strategic priorities of the Board.
Workforce Implications	Considered in Section 3 of the report
Financial Implications	Covered in section 2 of the report.
Route To Board Which groups were involved in contributing to the paper and recommendations.	Update on previous paper to the Board
Risk Assessment (Outline any significant risks and associated mitigation)	Significant financial and service delivery risk if this programme of work is not delivered. This financial and delivery risks are clearly set out in the paper.
Assessment of Impact on Stakeholder Experience	Failure to deliver this programme will have a likely adverse impact on the experience of patients and staff.
Equality Impact Assessment	Not formally assessed.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	13 December 2018
Agenda Reference:	Item No: 17
Sponsoring Director:	Finance and Performance Management Director
Author:	Head of Corporate Planning and Business Support/ Clinical Effectiveness Team Leader
Title of Report:	Performance Report Q2 2018/2019
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 Q2 July – September 2018. A summary table for the performance indicators may be found in Appendix 1. We have added Q1 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; GP access and Sickness Absence. Additional local KPIs are reported to the Board and included in this report. Going forward, the LDP process has been replaced by a requirement for each Board to submit an Annual Operational Plan for 2018-19. A review of the broader LDP standards is also being undertaken at a national level.

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, eight out of twelve KPI's, however overall there is deterioration in performance from four KPI's in comparison to Q1. The following areas of performance merit comment:

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

On 30th September there were 108 patients in the hospital. 9 of these patients were in the admission phase. 5 CPA documents had not been reviewed within the 6 month period. 2 were due to section dates and 3 were out of date. This gives a compliance of 94.9% which is a reduction from June's 100% compliance. This moves the indicator from green to amber.

Health Records staff are sending 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 are being 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

Changes will be made in Q3 to the way in which this data is presented. This is a follow on from some work that was completed for the Clinical Governance Group. The data will include enhanced details around patients off hub activities, which should show any trend easier.

For Q2, 79% of patients were involved in off-hub activities. This is a slight reduction since the last quarter (Q1 81.7%). This percentage doesn't include patients planned to attend the hospital shop or the patients scheduled to attend the Health Centre.

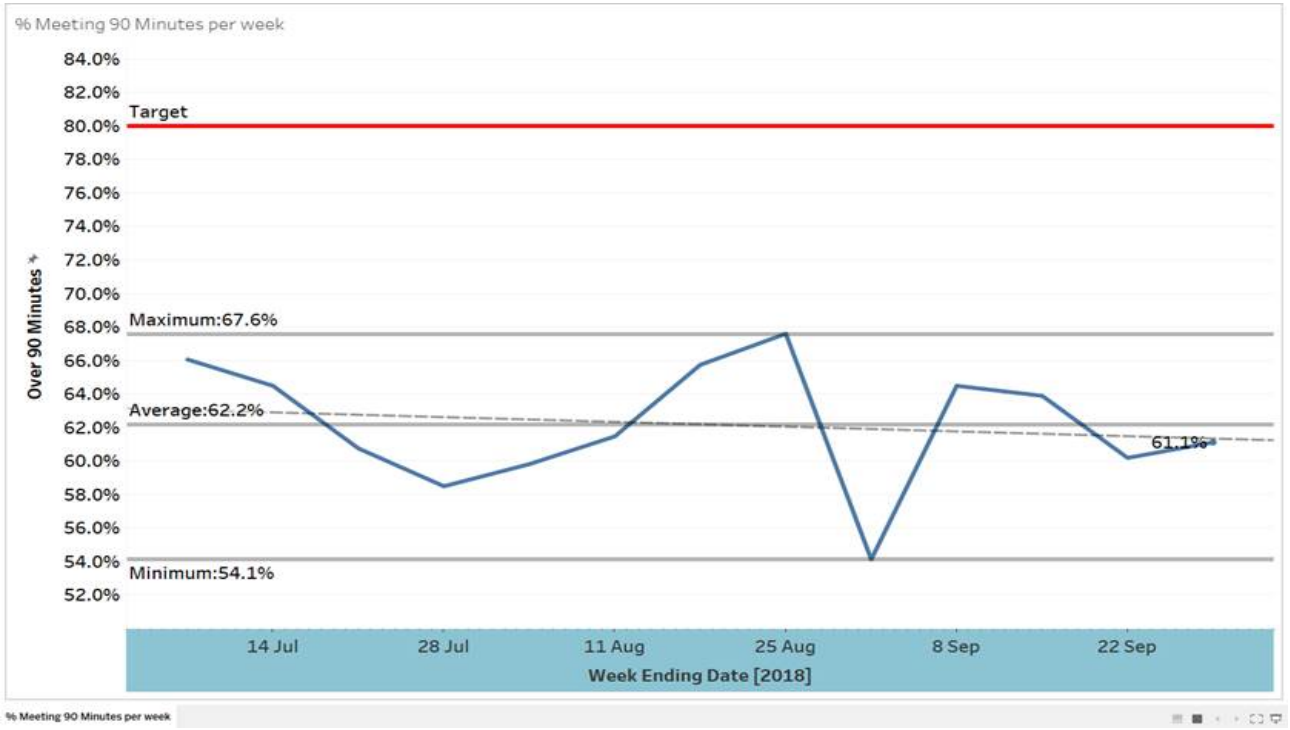
Reasons for the reduction include patients who completed the Skye Centre Induction in August and are waiting approval from Clinical Team to attend other activity centres. There were also 8 discharges over the Q2 with 6 of these patients having regular placements at the Skye Centre.
.

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

The process that integrates physical activity recording within the RiO Electronic Patient Administration System has now been implemented hospital wide. Reports are available that provide a personalised analysis for individual patients and can be used by Clinical Teams to target specific interventions. The Senior Information Analysts have also developed reports on levels of activity achieved overall by the Hubs.

Based on the promising early results, the Physical Health Working Group agreed to increase the target percentage from 60% to 80% of patients engaging in 90 minutes physical activity over the course of a week. Unfortunately there has been a decrease in compliance since the target was increased.

The percentage has decreased from 64.9% in Q1 to 62.2% in Q2. One of the main factors for the decrease in September is the changes to ground access times. Other reasons included the staffing issues within the hospital that restricted the number of escorted walks and the hub gym sessions that could be facilitated.



No 6 Healthier BMI.

The audit results show that 14.5% patients have a healthy BMI in Q2 compared to 18.8% in June 2018 (Q1) and 15.7% in December 2017. This is concerning but may be due to the patients that have been admitted and discharged within the time period. Two patients that were discharged were within the healthy category and the recent admissions were overweight or obese on admission. It should also be noted that this is the first reporting period where the weights are coming straight from RiO and not the 6 monthly anthropometrics check.

Table 1:

Weight Range by BMI	**Number of patients (Q1)**	% (Q1)	**Number of patients (Q2)**	% (Q2)
<18.5 underweight	0	0	1	0.9
18.5-24.9 healthy	19	18.8	15	14.5
25-29.9 overweight	26	81	30	85.5
30-34.9 obese	32		33	
35-39.9 obese	19		16	
>40 obese	5		8	

Overall the rates of overweight and obesity show an increase from 81% in June 2018 to 85.5% in September 2018. The Hospital target of 25% of the population being a healthy weight remains unachieved.

Table 2: The frequency and % of patients in BMI categories based on the NICE (2006) and SIGN (2010) guidelines for June 2018 in comparison with September 2018 are as follows:

	No of patients June 2018	**%**	**No of patients Sept 2018**	**%**
<18.5 (Underweight)	0	0	1	0.9
18.5-24.9 (Healthy weight)	19	18.8	15	14.5
25-29.9 (Overweight)	26	25.7	30	29.1
30-34.9 (Obese 1)	32	31.6	33	32.0
35-39.9 (Obese 2)	19	18.8	16	15.5
≥40 (Obese 3)	5	4.9	8	7.7
Total	**100**	**100**	**112**	**100**

No 7 Sickness absence.

The sickness absence figure from 1 September 2018 to 30 September 2018 is 6.83% with the long/short term split being 3.24% and 3.58% respectively. The total hours lost for this period is 6,621.79 which equates to 40.68 wte. The monthly absence figure has decreased by 1.44% from August 2018 figure of 8.27%. The August 2018 long/short term split was 4.28% and 3.99% respectively.
The current average rolling 12 month sickness figure is 8.94% for the period 1 October 2017 to 30 September 2018. The long/short term split is 6.89% and 2.05% respectively. The total hours lost for this period is 101,703.42 which equates to 52.15 wte. *(calculated on the total yearly data)*

No 8 Staff have an approved PDP.

July - 59.8%, August - 57.7%, 30 September – 60.3% giving an average of 59.2% for Q2.

It is worth noting that reductions in PDPR compliance levels were also being reported (anecdotally) in other NHS Boards. This reduction in compliance is likely, at least in part, to be linked to introduction of the new Turas Appraisal system (with staff requiring time to get familiar with the new system and associated requirements). Staffing resource pressures, high levels of staff absence and increased clinical activity are other factors that are likely to have contributed to the reduction in organisational compliance over the summer period.

The compliance report provided for this month's SMT (November) is, however, indicating some improvement in compliance so Q3 should show an improvement. This target remains in the red zone.

No 9 Patients transferred/discharged using CPA.

This indicator reduced from 100% in Q1 to 87.5% in Q2 This is due to one patient being discharged to hospice care during the quarter. There were 8 discharges in total and 7 had a discharge CPA. This moved the indicator from green to red but this is mainly down to the small number of discharges.

No 16 Attendance by clinical staff at case reviews.

RMO attendance has decreased from 92% in Q1 to 89% Q2 moving this indicator into the amber zone from green.

Key Worker attendance has increased from 58% in Q1 to 77% in Q2 moving it from red to amber

Occupational Therapy attendance has increased from 68% in Q1 to 75% in Q2 against a target of 80%. This moved from red to amber.

Pharmacy has decreased from 68% in Q1 to 59% in Q2. This moves them from green to amber.

Psychology attendance has decreased from 96% attendance in Q1 to 89% in Q2 against a target of 100%. This moved them from amber to red.

Security attendance has decreased further from 50% in Q1 to 34% in Q2 against a target of 60%. Attendance in Q4 2017/18 was 66%.

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 Q2	RAG Q1	Actual	Comment	LEAD
1.	8	Patients have their care and treatment plans reviewed at 6 monthly intervals	100%	A	G	94.9%	*Figures for Sept 2018.* The figure for June 2018 was 100%.	LT
2.	8	Patients will be engaged in psychological treatment	85%	G	G	94%	*Figures for Sept 2018* – 94% engaged in therapy. Of the 6 patients not engaged: 1 is involved in music therapy, 1 completed treatment in April, 1 due to start Psychodynamic Therapy, 2 completed treatment in August and 1 on the transfer list.	MS
3.	8	Patients will be engaged in off-hub activity centres	90%	R	A	*79%*	*Average figure for Apr-Jun 2018,* was 77% in Q4. Excludes shop / health centre information (brief visits).	MR
4.	8	Patients will be offered an annual physical health review	90%	G	G	100%	*Figures for July-Sept 2018.* All eligible patients were invited, 19 attended Annual Health Reviews, 11 admission physicals completed, 3 refused, 3 rescheduled.	LT
5.	8	Patients will undertake 90 minutes of exercise each week	80%	R	G	62.2%	The target has been increased from 60% to 80%. This is why the indicator has moved from the green zone to the red zone. Range 54.1%-67.6%	MR
6.	8	Patients will have a healthier BMI	25%	R	R	14.5%	*Figure from Sept 2018*, June figures was 18.8%	LT
7.	5	Sickness absence (National HEAT standard is 4%)	** 5%	R	R	6.83%	*Rolling figure for Sept 2018*. 9.73% in June 2018.	JW
8.	5	Staff have an approved PDR	*100%	R	R	59.2%	*Figure for 20 Jun 2018.* July - 59.8%, August - 57.7% and 30 September – 60.3%	JW
9.	1, 3	Patients transferred/discharged using CPA	100%	R	G	87.5%	*Figures for July-Sept 2018*. 8 patients discharged/transferred, one patient did not have a discharge/transfer CPA but this patient was discharged to hospice care.	KB
10.	1, 3	Patients requiring primary care services will have access within 48 hours	*100%	G	G	100%	*Figures for July-Sept*. 498 interventions all achieved within the appropriate timescale.	LT
11.	1, 3	Patients will commence psychological therapies <18 weeks from referral date	**100%	G	G	94%		MS
12.	1, 3	Patients will engage in meaningful activity on a daily basis	100%	-	-		*New indicators in development and being discussed at CGG December meeting*	MR
13.	2, 6, 7, 9	Patients have their clinical risk assessment reviewed annually.	100%	G	G	98.1%	108 patients. 15 new admissions, 91 patients with current CPA documents and 2 CPA documents out of date.	LT
14.	2, 6, 7, 9	Hubs have a monthly community meeting.	-	-	-	-	*New indicators in development and being discussed at CGG December meeting*	MR
15.		Refer to next table.						All Clinical Leads

Item	Code	Principles	Performance Indicator	Profession (Lead)	Target	RAG Q2	RAG Q1	Overall attendance July-Sept 2018 (Q2) (n=51)	Overall attendance Apr-Jun 2018 (Q1) (n=50)	Overall attendance Jan-Mar 2018 (Q4) (n=50)
16	T	2, 6, 7, 9	Attendance by all clinical staff at case reviews	RMO **(LT)**	90%	A	G	89%	92%	94%
				Medical **(LT)**	100%	A	A	96%	98%	96%
				Key Worker/Assoc Worker **(MR)**	80%	A	R	77%	58%	82%
				Nursing **(MR)**	100%	A	A	96%	96%	98%
				OT**(MR)**	80%	A	R	75%	68%	78%
				Pharmacy **(LT)**	60%	A	G	59%	68%	74%
				Clinical Psychologist **(JM)**	80%	G	G	80%	86%	74%
				Psychology **(JM)**	100%	R	A	89%	96%	88%
				Security**(DW)**	60%	R	R	34%	50%	66%
				Social Work**(KB)**	80%	G	G	80%	88%	68%
				Skye Activity Centre **(MR)** (only attend annual reviews)	tbc	-		0%	0%	0%
				Dietetics **(MR)** (only attend annual reviews)	tbc	-		0%	0%	0%

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	13 December 2018
Agenda Reference:	Item no: 18
Sponsoring Director:	Director of Finance and Performance Management
Author:	Director of Finance and Performance Management
Title of Report:	Information Governance Group Annual Report
Purpose of Report:	For noting

1 SITUATION

This annual report outlines the work carried out by the Information Governance Group (IGG) and Caldicott Guardian in order to convey it in a summary form to the Board.

2 BACKGROUND

The attached report summarises the work carried out by the IGG and Caldicott Guardian over the past year, including descriptions of new initiatives that have been developed and implemented in addition to the ongoing monitoring of progress against the Information Governance toolkit and Information Governance risk assessment.

3 ASSESSMENT

KEY ISSUES	SUMMARY OF IMPACT
Information Governance Standards	The group continues to utilize the toolkit as the means of self assessment of the standards. There has been a slight drop in our overall attainment this year which reflects staff turnover.
Information Governance Risk Assessments	Ongoing regular monitoring of risk assessments with action taken accordingly.
Information Governance Training	Increased levels of training completion. “Information Governance: Essentials” introduced as a new annual and mandatory training module (replacing “Overview”).
SUIs / CIRs	Implementation of recommendations from SUIs in progress.
Information Governance Datix Reports	Continuing review of Datix Incidents as they occur with action taken as appropriate.
Electronic Patient Records	Ongoing review of EPR development.
Information Governance Walkrounds	Continuing to have a positive impact on overall Information Governance practice.
FairWarning	System now fully operational and decreasing level of alerts noted.
Records Management	Records Management Plan approved by Record Keepers Office and related work ongoing.
Freedom of Information / Environmental Information Regulation Requests	The FOI self assessment toolkit has highlighted a number of areas for improvement. The group receives regular reports regarding FOIs and EIRs.
Subject Access Requests	No issues highlighted from regular reports of subject access requests

	received.
PMTS Project	Now fully implemented with the support and input of the Group.
General Data Protection Regulation / Data Protection Act 2018	A new Data Protection Policy and associated procedures were introduced in February 2018

Future Developments

The main areas to be addressed by the group in 2018/19 are

WORK / SERVICE DEVELOPMENT	**TIMESCALE**
Maintain and progress Information Governance module attainment levels	Ongoing
Update Information Governance training modules in line with GDPR/DPA18 requirements	April 2019
Continue Information Governance walkrounds	Ongoing
Implementation of Records Management Plan and associated actions in line with the Public Record (Scotland) Act	Ongoing
Support for the development of CELCAT or equivalent timetabling system	Ongoing
Support for RiO7 business case	Ongoing
Supporting development of the EPR (RiO)	Ongoing
Implementation of ICO guidance regarding GDPR / DPA18	Ongoing
Freedom of Information self assessment	Ongoing
Updated FOI Policy and measures to improve FOI response times	April 2019

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?	Information Governance is a key area for monitoring and reporting to support the Hospital's strategic objectives
Workforce Implications	Certain specific responsibilities require confirmation as noted in the report and these are being addressed.
Financial Implications	Specific projects have eHealth cost implications are considered within that department's budget.
Route to the Board (Committee) Which groups were involved in contributing to the paper and recommendations?	Information Governance Group report presented directly to the Board on instruction from the Chair, having formerly reported to Clinical Governance.
Risk Assessment (Outline any significant risks and associated mitigation)	Risk of information governance breakdown – addressed on each specific area by the IGG.
Assessment of Impact on Stakeholder Experience	Protection of confidentialities and of the Hospital's reputation.
Equality Impact Assessment	No potential inequalities have been identified.

THE STATE HOSPITALS BOARD FOR SCOTLAND

INFORMATION GOVERNANCE ANNUAL REPORT

APRIL 2017 – MARCH 2018

(Including Health Records)

Lead Author	Finance & Performance Management Director / SIRO
Contributing Authors	Health Records Manager
	Information Governance and Data Security Officer
	Risk Management Team Leader
	Senior Project Manager
Approval Group	The State Hospitals Board for Scotland
Effective Date	November 2018
Review Date	August 2019
Responsible Officer	Finance & Performance Management Director / Senior Information Risk Owner

Table of Contents

1 INTRODUCTION AND HIGHLIGHTS OF THE YEAR

The Information Governance Group, chaired by the Senior Risk Information Owner (SIRO) is responsible for progression of attainment levels in relation to Information Governance Standards.

The Caldicott Guardian principles have now been integrated within the initiatives and standards required by NHS QIS for Information Governance and attainment levels are recorded via the Information Governance Toolkit. Although there has not been a requirement to send the attainment levels to QIS or ISD since October 2011, we continue to internally monitor our attainment levels biannually on this basis.

From 2013 it was requested by the Chairman that this report (formerly the Caldicott Guardian Report) is submitted on an annual basis to the Board, replacing the previous requirement to report to the Clinical Governance Committee.

Over the last year the Committee has continued to work to improve Information Governance standards across the Hospital. We have encouraged staff to adopt good Information Governance standards through a number of measures undertaken by the group, and to complete mandatory online Information Governance learning modules. We have continued to adhere to recommendations included in the Scottish Government's "NHSScotland Information Assurance Strategy CEL 26 (2011)" document and as a result a regular schedule of Information Governance Walkarounds within the Hospital takes place, including non-patient areas. In addition the group has focussed on other key areas of priority such as the electronic patient record (EPR) system, the outcomes of the FairWarning system, and the full adoption of Vision (a GP electronic patient record) – together with ad hoc issues such as redaction practices and email scams. The Data Protection and a number of other information governance policies were updated ahead of the General Data Protection Regulation coming in.. A significant focus going forward into 2017/18 will be on GDPR (General Date Protection Regulation) and Records Management.

2 INFORMATION GOVERNANCE GROUP

2.1 Information Governance Group membership

Robin McNaught	Chair – Finance & Performance Management Director & Senior Information Risk Owner
Dr Duncan Alcock	Deputy Chair – Associate Medical Director, Caldicott Guardian & Medical Representative
Thomas Best	Head of eHealth
Kathy Blessing	Social Work Representative
Alison Buchanan	Clinical Secretary Co-ordinator
Moira Donoghue	Finance Representative
John Fitzgerald	Senior Information Analysts & Information Technology Security Officer
Ken Lawton	Information Governance and Data Security Officer & Data Protection Officer
Jackie McQueen	Nursing Representative
Karen Mowbray	Health Records Manager
vacant – awaiting nomination	Clinical Psychologist
Shona Smillie	Security Representative
vacant – awaiting nomination	Human Resources
Janet Warren	Skye Centre Representative
Nicola Watt	Risk Management Team Leader
Morag Wright	Pharmacy Lead
vacant – awaiting nomination	AHP Representative

2.2 Role of the group

The group has a wide reaching remit, being responsible for all matters in respect of Information Governance within the Hospital as the title suggests. The membership of the group is purposely broad. This allows the group to be representative of staff groups and departments from across the hospital.

2.3 Aims and objectives

- Ensure compliance and development of Information Governance overall as monitored by the IG toolkit.
- Address issues arising in the hospital in relation to Data Protection.
- Address issues arising in the hospital in relation to Health Records including structure, filing, storage, and archiving.
- Address Caldicott issues including monitoring DATIX reports and ensuring relevant training for staff.
- Provide a forum for the various staff groups within the hospital to raise any eHealth Information Governance issues and to receive feedback from eHealth on such matters.
- To monitor requests made in relation to Freedom of Information and Subject Access Requests.

2.4 Meeting frequency

The group has continued to meet on a bi-monthly basis to discuss any issues as outlined above. Following agreement from the wider group, a small subgroup – the IG Risk Assessment Group – also meets 6 monthly in order to concentrate on the assessment of the current attainment levels and supporting evidence required for the Information Governance toolkit self assessment, which is undertaken regularly. In addition this small sub group also meets 6 monthly to review the Information Governance risk register (see para. 3.2).

2.5 Strategy and work plan

As noted in previous reports, the Caldicott principles have now been integrated within the initiatives and standards developed by NHS QIS for Information Governance. The Information Governance Toolkit is completed twice yearly in order to monitor the performance of the hospital in relation to Information Governance. The schedule of work for the group is compiled in such a way as to allow the group to review progress with the Information Governance Standards. This monitoring allows the group to develop an action plan of work to be undertaken by the group members. In addition meetings are used to address the issues that may arise such as filing, relevant training, confidentiality issues etc. The group will continue to meet on a regular bi-monthly basis.

2.6 Management arrangements

The Information Governance Group now reports annually to the State Hospitals Board for Scotland through the IGG Report. The IGG also reports to the Senior Management Team as relevant.

3 KEY PIECES OF WORK UNDERTAKEN BY THE GROUP DURING THE YEAR

3.1 Information Governance Standards

In response to feedback from the Information Governance Team at ISD, following the implementation of Information Governance standards and Electronic Toolkit in 2007, the attainment levels for each of the standards were revised and new attainment levels introduced with effect from 2008.

The revised attainment levels within the Information Governance Framework have been agreed in partnership with NHS QIS to ensure that the Framework remains fully compliant with NHS QIS Improvement Framework.

In line with Clinical Governance and Risk Management (CGRM) standards a four point scale has been introduced that enables organisations better to demonstrate their compliance with the Information Governance Standards (IG). However there are differences between the stages of activities required to meet each level of attainment set within the CGRM standards and IG standards, the detail of which is listed below:

Level	CGRM Activities	IG Activities
1	Development	Developing and Implementation
2	Implementation	Developed and Fully Implemented
3	Monitoring	Monitoring and Evaluation of Effectiveness
4	Reviewing	Change Implemented in light of Continuous Review Cycle

The assessment of these attainment levels is a significant part of the workload of the Information Governance Group with a focus on achieving progress against the high standard of activities set within each level. As of 2013, six additional toolkit targets were added in relation to Administrative Records, bringing the overall number to 53.

The following is a summary of the attainment levels in recent years:-

Attainment Level	2013/14 *(Includes Admin Records)*	2014/15 *(Includes Admin Records)*	2015/16 *(Includes Admin Records)*	2016/17 *(Includes Admin Records)*	2017/18 *Includes Admin Records)*
1	2	7	6	3	2
2	3	1	3	3	5
3	2	0	0	1	0
4	46	45	44	46	46
Attainment of level 3 or better	90%	85%	75%	89%	87%

Generally we continue to maintain our previous attainment of Information Standards as shown by our monitoring through the Information Governance Toolkit. Of the targets where attainment level 4 has not been reached, the Group is hopeful that further progress can be made whilst at the same time maintaining the levels achieved on the other targets. The two attainment levels sitting at level one relate to information sharing and security, on which reviews are ongoing and will be revised during the change to The General Data Protection Regulations in May 2018. Those at level two saw a slight increase as a result of staff turnover and these are expected to return to level three in 2018/19. Work regarding Records Management and IT enhancements is ongoing, and these are also being addressed by the of the Records Management Plan and GDPR preparations. Over all we have achieved 87% in attainment levels three or four.

3.2 Information Governance Risk Assessments

Information Governance risks assessments are undertaken by a sub group of the IGG – the IG Risk Assessment Group – comprising the Caldicott Guardian, Health Records Manager and Information Governance and Data Security Officer. (This group first met in November 2011 to update risk assessments following the move to the new hospital site.) Following on from this the subgroup has met 6 monthly to review current Information Governance risk assessments and update accordingly. The Group is next scheduled to meet in July 2018.

There are currently 22 Information Governance risk assessments on the risk register covering a variety of risks (e.g. disclosure of loss of identifiable information through transportation of records, unauthorised access to health records areas).

On each occasion that the Information Governance risk assessment has been updated steps have been taken to minimise the risks highlighted (e.g. procedures to ensure identifiable information is sent recorded delivery; procedures re mobile devices; risks associated with staff leaving the organisation).

During the groups review relating to pending changes in data protection legislation, two areas were highlighted for action.

- Some older risks corresponding to electronic systems may be better mitigated using controls described in the information security standard (ISO 27001/2)
- Most risk assessments required an up to date privacy impact assessment to comply with the General Data Protection Regulation.

In the coming year, risks associated with IT systems will be considered for transfer to eHealth's risk register and privacy impact assessments will be conducted for all Information Governance risks.

The group expects a rise in identified risks during the coming year as the General Data Protection Regulation and Data Protection Act 2018 comes in to force.

3.3 Information Governance Training

The "Information Governance: Essentials" module was introduced in February 2017 as an annual requirement for staff and the "Overview" module was retired at the same time. All modules remain mandatory for all staff. Monitoring of completion rates by staff is undertaken by the Training & Professional Development Manager, with oversight by the IGG. The completion of the modules can be seen in the table below. The completion rates for the IG: Essentials module is expected to rise as it replaces the Overview module.

Information Governance module completion

Module	Mar 2014	Mar 2015	Mar 2016	Mar 2017	Mar 2018
IG: Essentials	n/a	n/a	n/a	31%	54%
Overview	89%	93%	97%	n/a	n/a
Confidentiality	87%	92%	95%	96%	97%
Data Protection	84%	91%	95%	96%	97%
Records Management	75%	86%	92%	94%	96%

The Group will continue review the contents of the modules to ensure that they continue to meet the needs of staff with the introduction of the General Data Protection Regulation and the Data Protection Act 2018 and expects that the modules will be updated as new guidance becomes available from The Information Commissioner's Office. Currently there are no national training modules for Information Governance that are aligned to GDPR

3.4 SUIs/CIRs

During the reporting period one SUI was undertaken which related to Information Governance The review focused on the incorrect completion of paperwork relating to patients. Following the review it was felt that processes could be improved to prevent any future Information Governance risk in these areas. The recommendations are pending.

The group continues to address recommendations from previous Information Governance incidents. The only other outstanding recommendation related to the sharing of information between social work and TSH staff. An information sharing protocol was drafted in accordance with national guidance and passed to senior social work colleagues for review, and is now being progressed.

3.5 Information Governance Datix Reports

While there were a number of patient related Information Governance incidents in the period, many of these incidents were relatively minor and related to use of NHS mail or sending information through the internal post. The IGG continues to address these issues by increased awareness of these problems and reiterated guidance relating to these issues through the staff bulletin.

Similarly there were a small number of incidents that related to staff and visitors. These were also relatively minor and related the use of NHS email, late notification of staff leaving or moving to different areas of the hospital and information sent by post. Changes have been made to the process for reporting notification of staff leaving and this will be monitored for improvement in the coming year.

We continue to encourage staff as to the importance of displaying high standards in relation to Information Governance Guidance notes are regularly circulated through the Staff Bulletin and Information Governance Walkrounds provide an opportunity for informal contact with staff to give guidance on Information Governance matters.

To support the roles of SIRO and Caldicott Guardian, those individuals attend SIRO training and the national Scottish Caldicott Guardian meetings. These meetings include elements of both professional development and practice updates. In addition there is regular participation in discussions on the national Caldicott Guardian electronic forum, plus membership of the national Caldicott Guardian Executive.

3.6 Electronic Patient Records

Members of the IGG were actively involved in the ongoing development of the EPR (RiO) – and the project-specific EPR Group continues to meet regularly. This has included ongoing involvement in development of the business case for RiO7, providing advice on Information Governance matters and regular audits of the electronic Health Records. A Health Records Audit was constructed. On the whole the audit has shown that staff are applying high standards when making Health Record entries, and there is regular reporting on the results of these audits. Through completion of a number of audit cycles we have identified some particular areas requiring improvement, and continue to review these with particular regard to the levels of unvalidated entries which – while reducing – require to be addressed on an ongoing basis. A new process was introduced in 2016/17 which was intended to improve compliance.

3.7 Information Governance Walkrounds

Having been introduced in 2015 as a recommendation following the publication of the NHS Scotland Information Assurance Strategy CEL 26 (2011) the Information Governance Walkrounds have built on the success of the previous years. The unannounced monthly walkrounds now occur a random throughout the year and encompass all areas of the organisation were personal information is used. The staff members involved in conducting these walkrounds continue to be impressed by the high standards of Information Governance that have been apparent in visited areas. Building on the success of last year's guidance on Clear Working Spaces and staff feedback during walkrounds, Work Spaces Procedures were introduced in February with expanded clear working spaces guidance.

Only a small number of minor issues have been encountered during the walkrounds, with all issues being appropriately resolved after communication with the relevant staff members and managers.

3.8 FairWarning

The group regularly receives reports on the levels of FairWarning alerts raised and a sub group is tasked with maintaining appropriate alerts and thresholds to provide a proportionate audit of access to personal information.

FairWarning alerting rate rose by 5% from 914 to 954 alerts, this change was anticipated and reflected changes in ward management, changes in the patient population over the year and an increase in the recorded use of personal information, up 21% from last year. This is the second consecutive year in which no incidences of inappropriate access being recorded. The group have been satisfactory assured that there are no areas of concern regarding inappropriate access.

3.9 Records Management

The group is active in its involvement in the development of the Hospital's Records Management Plan. This included attendance at national training and groups. The Records Management Plan was submitted in December 2016 and agreed by the Keeper of the Records in July 2017. Since then work has been ongoing to improve record keeping and management in the Hospital, with a group being set up with representatives from various disciplines to take this forward.

The main piece of work to come out of the Records Management Plan is the creation of an information asset register/business classification scheme. A records survey has been designed with Health Records staff assisting in the completion of this with colleagues throughout the Hospital. A database is being compiled with the information gathered to allow an oversight of what records are held.

Future plans are in place to complete the information asset register and put formal destruction plans in place for appropriate records. A rolling shredding programme has been put in place, with bulk shreds twice a year.

Staff have also been working with the National Records of Scotland to ensure permanent preservation of some State Hospital records, including both clinical and administrative. This project is ongoing and a Journal Club will be held to inform colleagues of this work.

Future plans include looking at records management within the State Hospital in the wider context, including the possibility of having a designated Records Services Department which would allow for consistency across the Hospital.

3.10 FOI / Subject Access Requests

The group is kept informed of all FOI requests and of the timescales achieved in responding to these, and also of the receipt and completion of subject access requests.

Number of Freedom of Information Requests					
	2013/14	2014/15	2015/16	2016/17	2017/18
Requests made	19	8	42	40	46
Completion rate within timescales	Unknown	63%	75%	75%	91%

A certified FOI practitioner has been appointed as part of the Information Governance and Data Security Officer role and they have engaged with the FOI Committee to drive a continuing improvement cycle based on the Scottish Information Commissioner's self assessment toolkit.

The toolkit comprises of four modules which each review particular areas for our FOI obligations providing a four point scale of performance (Unsatisfactory, adequate, good and excellent) and reviews the previous year's performance.

Public authorities, such as The State Hospital are expected to provide a minimum of 'adequate' performance, taking in to account their local setting.

Standards and Criteria	2016/17
Responding on time	Unsatisfactory
Searching for, locating and retrieving information	Unsatisfactory
Advice and assistance	Unsatisfactory
Publishing information	Unsatisfactory
Overall	Unsatisfactory

This toolkit is a new undertaking for the hospital and it is anticipated that an updated FOI policy will be required to align ourselves fully with its requirements. The updated policy is expected Q4 18. The initial assessment highlighted that the low volumes of FOI requests received mean that missing a target on a few FOI requests will result in an unsatisfactory performance.

The FOI Committee members, senior staff and those in key roles were provided FOI training in January. This in conjunction with a certified practitioner in FOI has raised the knowledge, skills and awareness regarding FOI across the organisation.

The GDPR bring changes to the subject access process, in particular changes to the timescales and charging structures, that will mean less time is available to complete a request and no charge can be made for the request, in most cases. These changes have been reflected in our GDPR updated policies and procedures and the group will monitor completion times to ensure that the hospital continues to meet its obligations in a timely manner.

Number of Subject Access Requests			
	2015/16	2016/17	2017/18
Requests made	138	19	13
Completion rate within timescales	90%	100%	92%

3.11 Patient Movement Tracking System (PMTS)

Members of the group assisted in the design and implementation of a replacement PMTS which went live in July. The project to bring a new PMTS was led by the Director of Security and the Senior Project Manager. This project progressed well to full implementation with safeguards to patient privacy embedded in the system and the operating procedures.

One of the main information governance challenges for this project was the relative ease previous systems data had been used for other projects. This project was delivered with a clear understanding that the information captured was only to be used for the purposes intended. Protocols were incorporated into the project to empower the PMTS owner to manage access to the application and to the underlying data.

3.12 MetaCompliance

MetaCompliance is a policy management system which is designed to ensure that key policies are communicated to all members of staff in order to ensure they obtain, read and understand their content. It also provides evidence of communication to line management and can identify individual staff members as having read and understood key policies.

In November 2017 the operation of MetaCompliance transferred to Information Governance which coincided with a review of policies deployed via the system.

Twenty one policies are currently delivered to staff for their acknowledgement, with the roll out of new and reviewed policies as they become available.

3.13 The General Data Protection Regulations / Data Protection Act 2018

In May 2018, the Data Protection Act 1998 will be replaced by the EU's General Data Protection Regulations (GDPR). This new framework comes into place as the UK enters the process of uncoupling from the EU, with the proposed Data Protection Act 2018 being used to apply the regulations in the UK.

The group has reviewed the Hospital's current practices and in conjunction the Information Commissioner's Office (ICO) guidance, national Information Governance Leads advise and Scottish Government advise, have aligned ourselves to meet the new regulation by insuring that;

- Awareness of the change in law has communicated to all staff, particularly to decision makers.
- We have documented the information we hold.
- Our privacy notices were updated and reissued
- We have reviewed our procedures to check data subject rights can be delivered
- Our subject access provision can adapt to the shorter timescales.
- We have recorded the legal basis for processing of personal data.
- Where we rely on consent, we have robust and fair processes to obtain and record it.
- Privacy by design has been adopted by the organisation, which is supported by data protection impact assessments where projects have a higher risk of affecting privacy.
- A qualified Data Protection Officer was appointed in November 2017.

An updated set of Information Governance policies and procedures was introduced in February 2018 to address GDPR requirements.

4 IDENTIFIED ISSUES AND POTENTIAL SOLUTIONS

We have continued to try to improve attendance at the IGG meetings as full attendance at this group can sometimes be difficult to achieve. We strive to encourage attendance by making the remit of the group relevant to staff member's roles and with this in mind we incorporated user feedback on the EPR (RiO) and wider user feedback on eHealth matters into the agenda for the group. The attendance by deputies in the event of diary pressures will be actively considered going forward.

There continue to be challenges in maintaining the high standards of Information Governance found in the hospital. We are actively as a group engaged in addressing these challenges.

5 FUTURE AREAS OF WORK AND POTENTIAL SERVICE DEVELOPMENTS

Work/ Service Development	Timescale
Maintain and progress Information Governance module attainment levels	Ongoing
Update Information Governance training modules with GDPR / (DPA) 2018 requirements	April 2019
Continue Information Governance walkrounds	Ongoing
Implementation of Records Management Plan and associated actions in line with the Public Record (Scotland) Act	Ongoing
Support for the development of CELCAT or equivalent timetabling system	Ongoing
Support for RiO7 business case	Ongoing
Supporting development of the EPR (RiO)	Ongoing
Implementation of GDPR/ DPA(2018)	April 2018
Freedom of Information Self Assessment	Ongoing

6 NEXT REVIEW DATE

August 2019

Board Paper 18/91

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	13 December 2018
Agenda Reference:	Item No: 19
Sponsoring Director:	Chief Executive
Author(s):	Board Secretary
Title of Report:	Annual Review – Update
Purpose of Report:	For Noting

1 SITUATION

A report was presented to the Board in October advising that a Ministerial Review would take place at The State Hospital on 14 January 2019. Scottish Government guidance also advised that a public engagement session should be held by the Board, and that this need not be on the same day as the Ministerial Review.

2 BACKGROUND

A plan has been submitted to the Minister for Mental Health for her visit on 14 January 2019 and this is attached at Appendix A. The public session has been arranged for the afternoon of 23 January 2019 in Carnwath Town Hall.

3 ASSESSMENT

The core purpose of the Annual Review will continue to be for Boards to be held to account for their performance, and the Board should note that self-assessment briefing for the Minister is due to be submitted in December 2018.

Ministerial Visit

The Ministerial Visit will include a meeting with the Clinical Forum and the Partnership Forum as well as a meeting with patients, carers and volunteers as has been the case in previous Ministerial Reviews.

This will be followed by a visit by the Minister to the Skye Centre and one of the hubs to meet with patients and staff and provide a focus on the therapeutic approach taken in the hospital.

The final part of the visit will be a meeting with the Chair and the Chief Executive.

Public Meeting

Due to the secure nature of The State Hospital, the public meeting will take place locally in Carnwath Town Hall. This meeting will be advertised to ensure that stakeholders in the hospital including the local population are aware of it. The intention is for the Chair to provide a presentation, and for this to be followed by a question and answer session. Senior Management will form a panel to ensure effective engagement during the question and answer session.

4 RECOMMENDATION

The Board is invited to **note** the arrangements made for both the Ministerial Visit and the Public Meeting.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	To support Scottish Government request
Workforce Implications	None identified
Financial Implications	None identified
Route To Board Which groups were involved in contributing to the paper and recommendations.	Scottish Government request
Risk Assessment (Outline any significant risks and associated mitigation)	None identified
Assessment of Impact on Stakeholder Experience	To be fully explored and reported as progress made
Equality Impact Assessment	Considered as part of scheduling/ arrangements as progressed

Appendix A

ANNUAL REVIEW (MINISTER)

THE STATE HOSPITALS BOARD FOR SCOTLAND

MONDAY 14 JANUARY 2019 AT THE STATE HOSPITAL, CARSTAIRS

Minister and SG staff to be dropped off at Hospital Main Entrance. Car Parking is available on site.

A private room has been set aside for the Minister and SG staff to use. Tea, coffee and water will be available throughout the day and a sandwich will be provided.

Timing	Activity	Room	Attendees / Notes
9:50 am	**Minister will be accompanied by SG team (TBC)** **To be welcomed by Terry Currie, Board Chair and Jim Crichton, Chief Executive**		
10:00-11.00	**Minister meets Clinical Forum (CF)**	**Harris Seminar Room**	Aileen Burnett – Chair of Clinical Forum Clinical Forum - Members (tbc) Lindsay Thomson- Medical Director / Chair of Clinical Governance Group
11.00–11.15	**Short Break**	**Harris Seminar Room**	Private for ministers and SG team
11.15-12.15	**Minister meets Partnership Forum (PF)**	**Harris Seminar Room**	James Crichton - CEO Anne Gillan – Employee Director Partnership Forum Members (tbc)
12.15-1pm	**Lunch Break /transfer to Skye Centre**	**Harris Seminar Room**	Sandwich lunch / transfer Private for Minister and SG Team
1pm – 1.30pm	**Minister meets Patients, Carers And Volunteers**	**Skye Centre – Vocational Room**	Patients (tbc) Carers (tbc) Volunteers (tbc) Terry Currie - Chair SHC representative (tbc) <u>Supported by</u> Sandie Dickson, Person Centred Involvement Lead
1.30pm to 2.45pm	**Visit Programme**	**Visit to Skye Centre and Hub**	Mark Richards, Director of Nursing and AHPs Jacqueline Garrity, Sky Centre Manager Catherine Totten, Lead AHP Jackie McQueen – Lead Nurse Sandra Macalister – Lead Nurse
2.45pm– 3.15pm	**Pre-meeting - SG Officials**	**Boardroom**	Private for Minister and SG Team
3.15pm – 4.45pm	**Annual Review Private Session**	**Boardroom**	Terry Currie, Board Chair Jim Crichton, Chief Executive
4.45pm	**Minister departs**		

THE STATE HOSPITALS BOARD FOR SCOTLAND

Minutes of the meeting of the Audit Committee held on Thursday 20 September 2018 at 9.45am in the Boardroom, The State Hospital, Carstairs.

PRESENT:

Non Executive Director	Elizabeth Carmichael **[Chair]**
Employee Director	Anne Gillan

IN ATTENDANCE:

Internal

Chief Executive	Jim Crichton
Procurement Manager	Tom Hair [Item 5]
Security Director	Doug Irwin [Items 6 and 7]
Finance and Performance Management Director	Robin McNaught
Head of Corporate Planning and Business Support	Monica Merson
Clinical Operations Manager	Brian Paterson [Items 4 - 8]
Interim HR Director	Kay Sandilands [Items 1 - 10b]
Personal Assistant	Julie Warren

External

Assistant Manager, RSMUK	Sue Brook
Senior Manager, RSMUK	Asam Hussain
Head of Internal Audit, RSMUK	Marc Mazzucco (via teleconference)

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

Mrs Carmichael welcomed everyone to the meeting. Apologies for absence were noted from Mr Bill Brackenridge, Mr Terry Currie, Ms Karen Jones and Mrs Marie Whitehead.

NOTED

2 CONFLICTS OF INTEREST

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

NOTED

3 MINUTES OF THE PREVIOUS MEETING

The Minutes of the previous meeting held on Thursday 28 June 2018 were approved following amendment to page 1, item 6 heading to read Internal Audit i.e. remove wording of 'follow up reports'.

NOTED

4 MATTERS ARISING AND ACTION NOTES UPDATE

Members received and noted the Summary Action Points, and that updates would be provided during this meeting.

In light of the review of Human Resources (HR) capacity Mr Crichton advised that staffing capacity had been enhanced through the Service Level Agreement (SLA) in place with NHS Lanarkshire and that this should address the backlog. This was welcomed together with the early indication that

staffing absence rates were beginning to see a decrease. Mr Crichton advised that it was crucial to maintain the sustainability of this model going forward.

Mrs Sandilands advised that the HR Department had retained one member of staff from NHS Lanarkshire and that it was expected that the department will return to full compliment soon. Mrs Gillan added her understanding in relation to the previous lack of capacity within HR and that the department appeared to be moving in the right direction. Mrs Sandilands reassured the Committee on going forward with robust plans and maintaining the focus on attendance management. Mrs Carmichael noted that there would be continued oversight in this area by the Staff Governance Committee.

Action – M Smith

In light of the Patient Activity Audit which was remitted to the Clinical Governance Committee on 9 August 2018, Mrs Carmichael updated the Committee that the issues around the existing model and the practical difficulties found in going forward had been discussed. It was highlighted that it had not been possible to roll out the model at the start of September 2018. Mr Paterson was now leading the Patient Active Day project and advised that the Patient Active Day Steering Group was being progressed.

He advised that further work required to be completed around this, involving Arran 2 patients moving to the Skye Centre one day per week for a four week period. Mr Paterson advised that current feedback from patients was that the full day was not optimal for them so consideration had been given to split into two and a half days. The issue could be problematic if patients were too mentally unwell to move to the Skye Centre.

Mrs Carmichael queried how progress would be measured. It was noted that timelines had been set through the Clinical Governance Group and, if required, that Members could seek assurance from this Group around monitoring. The Clinical Governance Group would next meet on 15 November 2018. Mrs Brook added that although the new model was still being tested, the drive remained to engage patients in activity with the same end goal agreed. Mr Crichton agreed that there should be continued focus on this challenging area to seek to close the gap in attendance in the context of quality improvement.

Mrs Carmichael highlighted the number of internal audit reports including the two later on the agenda, which had received partial assurance in the current financial year. It was particularly important to follow through on each recommendation with a view to attaining reasonable assurance overall before the end of this financial year. Mr Mazzucco proposed reviewing progress again in early 2019 as this was of high priority. Mr Crichton confirmed that every effort would be made to pick up the pace on the responses and to close the gaps. Mrs Carmichael confirmed that she had asked the Chairs of the Clinical Governance and the Staff Governance Committees to keep progress under review at the next meetings of these Committees. The Committee welcomed this plan and agreed to review progress at its January meeting.

Action – M Smith

<u>NOTED</u>

5 PROCUREMENT STRATEGY AND ANNUAL REPORT

A report was submitted by the Director of Finance and Performance Management which outlined activity within the function, as well as strategic focus in this area – the report provided an overview of how the organisation would meet the aims and objectives and deliver value for money. Mr Hair summarised the report for the Committee, advising that the report was slightly different in format from previous reports as requested by the Scottish Government.

Mrs Carmichael asked what the governance arrangements are around the Sustainable Procurement Policy and its reporting arrangements. Mr Hair confirmed that feedback on this would be included in the next Procurement Annual Report. Mrs Carmichael queried the question marks

against the policy for the Advisory Group and Mr Hair confirmed that the Advisory Group would be the Sustainability Development Group.

The Committee noted the content of the report and were happy to agree the recommendations. Mrs Carmichael took the opportunity to thank Mr Hair and his team for all their hard work and efforts.

NOTED

6 SECURITY AUDIT UPDATE

A report was submitted by the Security Director, Mr Irwin, who was in attendance to lead Members through the key highlights.

The Committee noted the content of the Physical Security Audit and the Forensic Network Audit and approved the actions outlined to address areas for improvement.

APPROVED

7 PATIENT PROPERTY POLICY

A report was submitted by the Security Director, which provided advice on action taken following internal audit recommendations regarding management of patient property, as well as a recommendation from the Senior Management Team in response to a Serious Untoward Incident review.

Mr Hussain considered that the paper was pragmatic and queried whether the hospital received claims in relation to patients' lost property. Mr Irwin advised that there has been approximately two or three cases in the last year with a cost implication. Mr McNaught confirmed this and advised that the hospital had a liability in such circumstances.

The Committee noted the content of the report and the anomalies created, and approved an alteration to the policy. Members retrospectively acknowledged that the original KPMG recommendation could not be met.

Mrs Carmichael recognised that this would be Mr Irwin's last attendance at an Audit Committee in view of his impending retirement and therefore took the opportunity to thank him for all his hard work and dedication during his time in the hospital. Mrs Carmichael added that his reports and presentations had consistently been very clear and that the Committee wished Mr Irwin well for the future.

APPROVED

8 PROGRESS REPORT 2018/19, INCLUDING TRACKING REPORT

The Committee received a report from RSMUK which outlined the progress made against the internal audit plan for 2018/19. Mr Hussain led Members through the key highlights of the report.

Mr Hussain advised that good progress had been made and drew attention to page 5 of the report 'Looking Ahead 2018/19' regarding the assignment areas and status of these. The Tracking Report confirmed that more actions had been completed: 38% had been closed as implemented, 19% not completed by due date, 33% still had work ongoing. Mr Crichton's view was that actions required to be realistic and due dates may need to be amended if this was not the case. He advised that the relevant Directors would meet and review outstanding actions in the next two weeks and will report back to RSMUK.

Action: Mr Crichton/ Mr McNaught

The Committee concluded by emphasising the high value of work of internal audit.

NOTED

9 POLICY AND PROCEDURE COMPLIANCE REPORT

The Committee was asked to note a report from RSMUK which provided internal audit opinion on policy and procedure compliance (Dignity at Work, Dealing with Employee Grievances; and Management of Employee Conduct). Taking into account the issues identified, the Committee was advised that the Board could take partial assurance that controls were in place in this area.

Mr Hussain advised of a correction to page 2 under 1.2 in that the second paragraph should state six medium priority actions and not five. Mr Hussain advised the Committee that it was important to note that it had been a challenging time for the Board and that some investigations were taking longer than expected due to multi-factorial reasons. Mrs Gillan advised that the key findings had been discussed at Staff Governance Committee. Mrs Sandilands advised that there have been changes since the report was developed – particularly that a reporting mechanism had been commenced.

The Committee noted the recommendations made in the report within the timescales stated.

NOTED

10a SICKNESS AND ABSENCE MANAGEMENT REPORT

Members were asked to note a report from RSMUK which provided the Committee with an overview of the progress of actions taken to implement the recommendations made in the earlier report presented in April 2018. Taking account of the issues identified, the report advised that the Board could take partial assurance that the controls in place to manage this area were suitably designed and consistently applied.

Mr Hussain advised Members that it had been found that there was still weakness in Line Managers not consistently filing documentation (i.e. sick lines, return to work forms) with HR, and that the HR department does not consistently record their receipt. The report also found that there had been a lack of active support from HR to line managers to help ensure policy compliance. Mrs Gillan raised the issue of a weakness in Line Managers not having the appropriate training or knowledge. Mr Hussain and Mrs Sandilands agreed to liaise in taking this further forward.

Actions – K Sandilands/ A Hussain

It was noted that Mr Crichton was taking a lead personally in this area through the Attendance Management Task Group and there should be consideration of a nominated lead in this area following Mr Crichton's retirement in March 2019.

Mrs Sandilands reassured the Committee that sickness absence remains a high priority and focus will continue to be on this over the next few months. Members underlined the need for the Board to ensure compliance with policy.

The Committee noted the content of this report and recommended actions, within the timescales provided.

NOTED

10b ATTENDANCE MANAGEMENT UPDATE

Members were asked to note a report from the Interim Human Resources Director which provided an update on sickness absence within the organisation for the month June 2018, and placed these within the context of national reporting.

Ms Sandilands was in attendance to provide an update on the key issues for Members. Mrs Sandilands advised that compliance with EASY had remained high, but that there had not been a reduction in the sickness level in the June figures.

Mrs Sandilands acknowledged that the HR Department required to continue to support line managers to manage staff absence appropriately, and that impact needs to be evidenced from the EASY process.

The Committee noted the content of this report, particularly the continuing high levels of absence.

NOTED

11 FRAUD UPDATE

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

Mr McNaught summarised the report for Members and highlighted the key priorities. Two Counter Fraud Service alerts had been issued since the last meeting of this Committee, and had been circulated as appropriate within The State Hospital.

The Committee noted the report, the alerts in the last quarter and actions taken.

NOTED

12 FRAUD ACTION PLAN

Members received a report from the Director of Finance and Performance Management which provided an update on the Board's approach to countering fraud.

Mr McNaught updated Members in terms of CFS liaison and monitoring. Counter Fraud Services had presented on anti-bribery and corruption to senior staff in April 2018. Mr McNaught highlighted that appendix 2 of the plan summarised the top ten fraud risks identified from the completed Fraud Risk Assessment, which were unchanged from the last reporting cycle.

The Committee noted progress on engagement activities, the update on communication and the fraud Action Plan, as well as the top ten risks to the organisation as outlined.

NOTED

13 RISK MANAGEMENT ANNUAL REPORT

Members received a report from the Director of Finance and Performance Management which outlined the annual review of activity within the Risk Department during 2017/18.

Ms Merson led Members through the report, highlighting the key issues.

From the summary provided, Members noted the key work undertaken by Risk Management in 2017/18 including ongoing work around risk registers; resilience planning; high graded incidents and health and safety training in relation to Control Books. The report also detailed the work underway in relation to Patient Safety Group.

The report highlighted areas of good practice, issues currently being addressed and areas to be focused on for future work and service development. In summary it has been a challenging time for the Risk Department and staff had worked hard to maintain service continuity.

The Committee were content to note the report.

NOTED

14 POLICY UPDATE

The Committee received a report from the Director of Finance and Performance Management which provided an update on the programme of work underway to monitor policy reviews.

It was confirmed that no one group within the hospital was responsible for monitoring policy review. Health and Safety, Infection Control, PMVA ad Information Governance detail policy review as part of their work plans, and these had demonstrated improved compliance. Responsibility for coordination of policies was now being taken forward by Clinical Effectiveness.

Mr McNaught advised that the paper noted progress on outstanding policy reviews and that progress had continued to be made in this area. Of 132 available policies, 28 were out of date. It was recognised that the process had changed recently, and that progress was being made. However, there were a number of reviews remaining and each policy holder was monitored regularly to ensure that these were being taken forward. The improved HR staffing position now in place was expected to make a positive impact on their outstanding review level.

The Committee were content to note the review of policies and actions being taken to ensure further progress.

NOTED

15 EFFECTIVENESS OF AUDIT COMMITTEE

Members received a report from the Director of Finance and Performance Management provided advice on the requirement for self-assessment by the Committee, as outlined by the Scottish Government Audit Committee Handbook.

The Committee had completed the Self Assessment Checklist, in line with the Scottish Government Handbook in late 2016, with recommendations being identified through this process. Mr McNaught led the Committee through a summary of these recommendations to open discussion in this area.

Mr McNaught advised that it had been agreed in 2016 to repeat this exercise two years later. This had been completed with the results collated and feedback highlighted for any actions identified. In the absence of all Members at this Committee this discussion would be taken forward further at the next meeting.

Action: M Smith

In view of her retirement at the end of November 2018, Mrs Carmichael confirmed that she would be willing to meet the new Chair when appointed, and provide a handover.

NOTED

16 DRAFT AUDIT COMMITTEE WORKPLAN 2019

The Committee received the draft workplan for 2019. Mrs Carmichael opened discussion of this with Members.

Mr McNaught advised that the draft workplan was attached for comment and approval. He advised that the workplan was flexible and could be amended in the light of developing priorities for the Committee. In relation to dates for meetings in 2019, members had been asked to respond to Ms Smith on the suitability of those projected in the workplan. Once the dates were agreed at the October Board meeting, members should note the dates to ensure good attendance.

Mrs Carmichael queried whether the Audit Committee be held in March rather than April 2019 for Members to meet prior to the end of the financial year. Mrs Carmichael agreed to speak to Ms Smith regarding this.

Action – Ms Smith

The Committee agreed the amended workplan.

APPROVED

17 ANY OTHER BUSINESS

There were no further items of competent business.

Members acknowledged that it was Mrs Carmichael's last Audit Committee and thanked her for all her hard work, support and dedication to the Committee.

NOTED

18 DATE AND TIME OF NEXT MEETING

The next meeting would take place on 24 January 2019 in the Boardroom, The State Hospital, Carstairs.

The meeting ended at 11.50am.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	13 December 2018
Agenda Reference:	Item No: 21
Sponsoring Director:	Chief Executive Officer
Author(s):	Chief Executive Officer
Title of Report:	Chief Executive's Report
Purpose of Report:	For Information

1 BACKGROUND

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

2 GENERAL ISSUES OF NOTE

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

Service Pressures
November saw a continuation of workforce pressures and challenges in meeting the full staffing requirement. A week of informal action between the 3rd and 10th of November aggravated the staff availability challenge and required significant adjustments to care delivery. Two areas of action have seen a positive impact in recent weeks:

The Attendance Management Task Group has progressed a programme of improvements in relation to support for staff managing absence. The targeted improvement of 3% was met within the first 8 weeks of the programme and the aim will be to sustain this improvement going forward.

Recruitment to substantive vacancies and the Nurse Pool has brought additional capacity to the nursing workforce which will in turn reduce pressure on additional hrs usage. Further recruitment is being progressed with a view to additional staffing joining the pool by March 2019.

Rostering review
Work undertaken on the review of rostering with the support of Meridian has been concluded early to allow a focus on the clinical model review being taken forward over the next 3 months. A staff survey has been launched in support of this and 2 stakeholder events will be held in February to evaluate the feedback and any implications for the delivery of care. Nursing workforce advice will be provided by Scottish Government to support the Board and ensure effective delivery of the service model going forward.

Staff engagement sessions
As part of the work of the Attendance Management Task Group, it was agreed that a series of Chief Executive led staff engagement sessions would take place to share information about current challenges within the service including staff absence and to engage with staff regarding their ideas and suggestions for change. The focus would be on empowering staff to influence the direction and effectiveness of the organisation in tackling these key issues and for management to respond

to those ideas. Twelve meetings took place over October and November 2018 covering a total of 138 staff. Overall the sessions were generally well received with a number of themed recommendations were taken from the sessions to support improved attendance. A paper with recommendations will be shared with the Staff Governance Committee and auctioned by the Task Group.

EU Withdrawal Update
The Chief Executive is working with Scottish Government and colleagues in other Boards to ensure a consistent approach to the management of service risks associated with EU withdrawal. Further guidance is anticipated in December following consideration of the proposed withdrawal arrangements by the UK parliament.

Appointment Of Security Director
We were pleased to welcome David Walker to the Board as Director of Security and Estates. David joins us from Police Scotland and has an established relationship with the State Hospital through his previous roles.

National Projects
In support of national priorities the Chief Executive undertook the following activities

- Chaired a meeting of the National FCAMHS Advisory Group on 30th November.
- Chaired meetings of the National Boards Internal Support Services Transformational Project Board on the 5th November and 3rd December.
- Chaired a meeting of the Police Health Care Network on the 29th of November.
- Attended meetings of the Scottish Medicines Consortium, National Boards, National Evaluation Committee and Chief Executives Meetings over November and December
- Supported the appointment of a new Chief Operating Officer for Acute Services in Fife.

3 PATIENT SAFETY UPDATE

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

Improving Observation Practice (IOP) Workstream

Improving Observation work is ongoing and growing in strength throughout the hospital. Iona Hub is now working well in looking at improving ways of working, in regards to IOP and is working closely with the IOP Lead in regards to increased levels of observation. In particular Iona Ward 1 has embedded the pivotal component of early intervention into their practice and successfully been able to avoid unnecessary increases of observation by looking at specific needs of two patients in particular and created a holistic treatment plan which has allowed least restrictive practice and positive risk taking. Iona and Mull Hubs continue to utilise the Clinical Pause which is now fully embedded and is now beginning to be tested within Arran Hub and commence within Lewis Hub in the New Year.

Risk Assessment and Safety Planning
The Dynamic Appraisal of Situational Aggression (DASA) is a tool that has been developed to assess the likelihood that a patient will become aggressive within a psychiatric inpatient environment. This has been rolled out across all mental health wards.

Communication at Transition
There have been no issues to report with the use of the use of the laptop whilst patients are boarding at a general hospital. Consideration is being given as to other projects that could take place under this workstream.

Safer Medicines Management
Work is ongoing to ensure the high standard of PRN completion remains throughout the transition of this information being recorded on RiO.

Least Restrictive Practice
The Clinical Pause continues to be rolled out to all hub's within the hospital, led by Dr Skilling. A Journal Club event is scheduled to present on this topic.

Leaders hip and Culture
Since the last report 3 walkrounds have taken place – Skye Atrium, Sports & Fitness and the Health Centre. Actions arising as a result of these walkrounds are now discussed at the weekly Chief Executive Business Meeting with owners assigned to the actions. Eight walkrounds have taken place across the site in 2018.

The Patient Safety group are keen to continue with Quality Improvement projects and maintain links with other groups in the hospital such as PMVA, TSH3030.

4 HEALTHCARE ASSOCIATED INFECTION (HAI)

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. There has been a notable improvement in submissions since April. The Senior Nurse for Infection Control (SNIC) will continue to contact individual wards which are non compliant to allow a late submission.

- Scotland's Infection Prevention and Control Education Pathway (SIPCEP). The compliance data shown is from launch of the program in November until June 2018. A 12month summary will be provided to the Infection Control Committee in December.

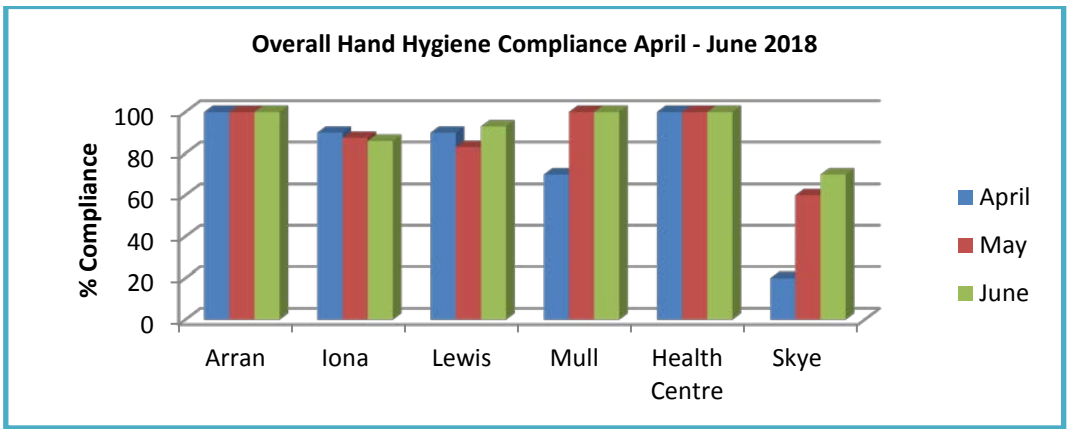
- The Standards of Dress and Clinical/Non-clinical Uniform Policy has been approved by the Senior Management Team and was launched on Monday 5th February 2018. Audit October 2018. Initial observations would seem to show a relatively high compliance with the policy.

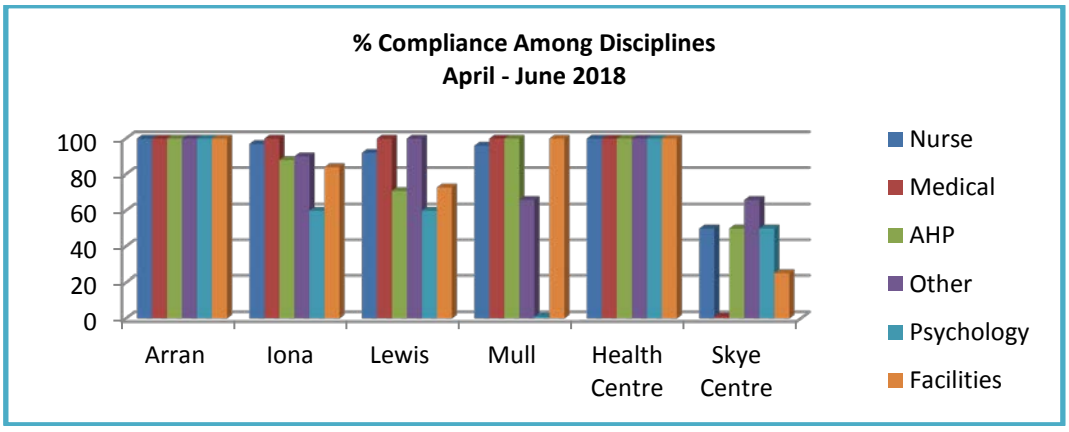
Audit Activity:

Hand Hygiene
During this review period, there was a notable increase in the number of audits submitted. Reminders to submit and follow up of non compliance will continue to be carried out by the Senior Nurse for Infection Control.

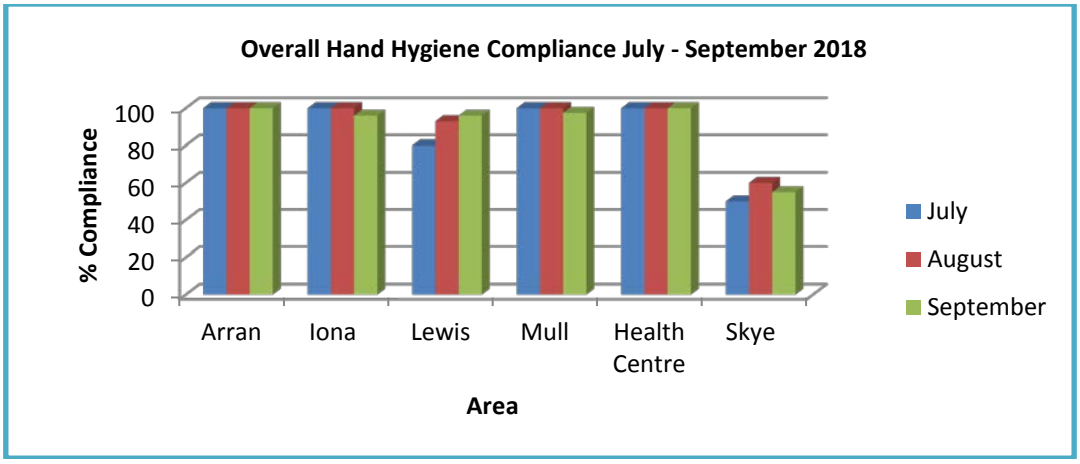
	April	May	June	July	Aug	Sept
Arran 1	Yes	Yes	Yes	Yes	Yes	Yes
Arran 2	Yes	Yes	Yes	Yes		Yes
Iona 1	Yes	Yes	Yes	Yes	Yes	Yes
Iona 2	Yes	Yes	Yes	Yes	Yes	Yes
Iona 3	Yes	Yes	Yes	Yes	Yes	
Lewis 1		Yes	Yes	Yes	Yes	Yes
Lewis 2	Yes	Yes	Yes	Yes	Yes	Yes
Lewis 3	Yes	Yes	Yes	Yes	Yes	Yes
Mull 1	Yes	Yes	Yes	Yes	Yes	Yes
Mull 2			Yes	Yes	Yes	Yes
Health C	Yes	Yes	Yes	Yes	Yes	Yes
Skye	Yes	Yes	Yes	Yes	Yes	Yes

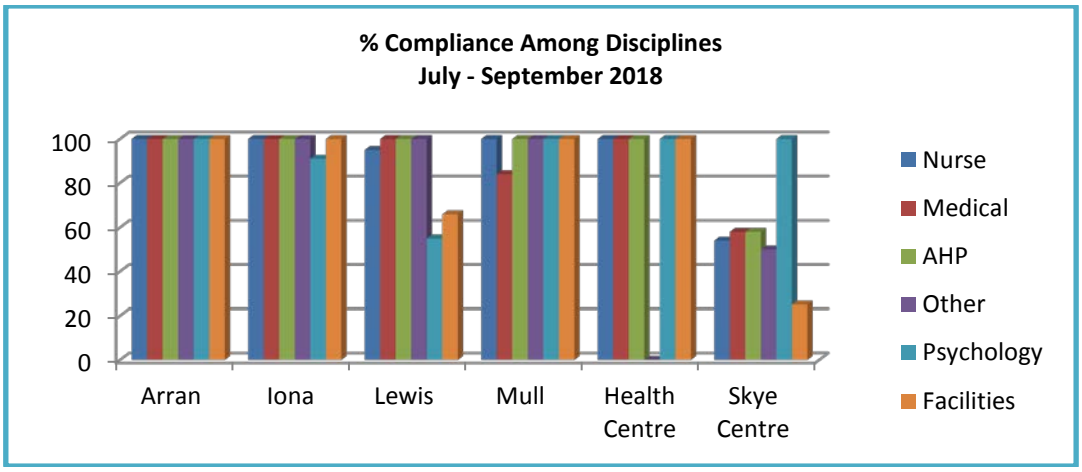
Quarter 1


Overall Hand Hygiene Compliance April - June 2018
% Compliance
100
80
60
40
20
0
Arran
Iona
Lewis
Mull
Health Centre
Skye
April
May
June


% Compliance Among Disciplines
April - June 2018
100
80
60
40
20
0
Arran
Iona
Lewis
Mull
Health Centre
Skye Centre
Nurse
Medical
AHP
Other
Psychology
Facilities

Quarter 2





The overall hand hygiene compliance within the hubs varies between 80-100%, Skye Centre 55-60% and health centre consistently attaining 100%. Within the hubs facilities and psychology are the lowest for Hand Hygiene Compliance.

Following approval by the Senior Management Team both the product and the location of the hand gel within the Skye Centre was changed. This change occurred in September 2017, indications would show that the positioning and change in product has not made any significant difference. Nationally Hand Hygiene products are being reviewed and following the Commodities Advisory Panel Recommendations the products used within the hospital may have to change. Until this has been agreed no further changes to products will occur.

The importance of Hand hygiene was promoted via the OneLan system within the Skye Centre during September; however there has been no improvement noted.

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

Following the poor compliance (end of June) with the 4 core modules the ICC agreed to provide a 3month extension and prioritize these modules. In addition to the current management of mandatory learning by the Learning Centre, Mark Richards agreed to pursue this with individual line managers.

This will be discussed again at the ICC in December.

Training figures displayed on next page.

Core Module	Nov 2017- March 18	April 2018 – June 2018
Why Infection Control Matters	301 (44.9% of target)	381 (56.8%)
Breaking the Chain of Infection	362 (54% of target)	443 (66%)
Hand hygiene	315 (47% of target)	398 (59.3%)
Respiratory and Cough hygiene	308 (45.9% of target)	384 (57.2%)
Role Specific Modules		
Safe disposal of waste (inc Sharps)	*165 (35.9% of target)*	*207 (44.4%)*
PPE	*174 (38.9% of target)*	*218 (47.8%)*
Prevention and Management of Occupational Exposure (inc Sharps)	*166 (36.1% of target)*	*210 (45.1%)*
Blood and body fluid spillages	*201 (45.2% of target)*	*244 (54.2%)*
Safe Management of Care Environment	*120 (30.9% of target)*	*159(40.1%)*
Safe Management of Care Equipment	*88 (26% of target)*	*118 (34.45%*
Safe Management of Linen	*120 (30.9% of target)*	*161(41.1%)*
Patient Placement/ Infection Risk	*92 (27.9% of target)*	*126 (37.6%)*

As of the end of June 2018 a total of 372 staff (55.4% of the total target group) had completed all 4 core modules. The details below are from departments where the completion rate for all 4 core modules is below 60%.

HR	0%	**Estates**	37.90%
Social Work	18.20%	**Mull 2**	41.40%
IT	27.30%	**Lewis 1**	42.90%
Procurement	28.60%	**Lewis 3**	44.80%
Mgt Centre	33.30%	**AHP**	46.20%
Iona 2	33.30%	**Psychology**	48%
Arran 2	34.50%	**Mull 1**	50%
Arran 1	37%		

Hand Hygiene – There are currently 17 staff who have not completed the hand hygiene module. The majority of these people are fairly new employees however 5 staff are individuals who had not previously completed the old hand hygiene module.

Healthcare Environment Inspection (HEI):

The Standards of Dress and Clinical/Non-clinical Uniform Policy has been approved by the Senior Management Team and was launched on Monday 5th February 2018. An audit of the policy was undertaken in October and the results are currently being finalised and will be presented to the subgroup early December. Anecdotal information would indicate that compliance is relatively high.

Summary
During the review period a number of improvements have been noted, in particular with the sustained improvement in Hand hygiene audit submissions. The next challenge will be to:

- Improve compliance across all disciplines and within the Skye Centre for Hand hygiene.
- Improve / monitor compliance with the SIPCEP core modules and report outstanding areas to the Infection Control Committee.

5 PATIENT ADMISSION / DISCHARGES TO 12 OCTOBER 2017

A detailed report on admissions and discharges is provided to the Clinical Governance Committee on a 6 monthly basis.

The following table outlines the high level position from 13 October to 2 December 2018.

	MMI	LD	Total
Bed Complement	128	12	140
Staffed Beds (i.e. those actually available)	108	12	120
Admissions	3	1	4
Discharges / Transfers	1	0	1
Average Bed Occupancy as at 2 December 2018			111 Patients 92.5% of available beds 79.3% of all beds

6 RECOMMENDATION

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

28 February 2018	25 April 2018	20 June 2018	22 August 2018	24 October 2018	19 December 2018
• Board Minute and Actions • Chair's Report	• Board Minute and Actions • Chair's Report	• Board Minute and Actions • Chair's Report	• Board Minute and Actions • Chair's Report	• Board Minute and Actions • Chair's Report • Annual Schedule of Board/Committee meetings	• Board Minute and Actions • Chair's Report
• Governance Committee Minutes • Clinical Forum Minutes	• Governance Committee Minutes • Review of Board Effectiveness	• Various Governance Committee Minutes • Governance Committee Annual Reports	• Various Governance Committee Minutes	• Various Governance Committee Minutes	• Various Governance Committee Minutes •
• Forensic Network Annual Report • Patient Learning Annual Report • Transformation • Clinical Model – Update	• Patient, Carer & Volunteer Stories • Clinical Forum Annual Report • Transformation • Nurse and AHP Revalidation – Update	• Skye Centre Report • Transformation	• Patient, Carer and Volunteer Stories • Medical Appraisal and Revalidation • Implementation of Specified Persons Report • Transformation	• Educational Supervisor Annual Report • Transformation	• Patient, Carer and Volunteer Stories • Person Centred Involvement Annual Report • Patient Advocacy Annual Report • Transformation
• Attendance Management – Update	• iMatter Report • Values & Behaviours Report	• Workforce Plan - Update			
• Finance Report • Performance Report (Q3 2018/19)	• Finance Report • Draft Operational Plan • Performance Report (Q4 2018/19) • Annual Review of Standing Documentation	• Finance Report • Annual Accounts • PAMS • eHealth Annual Report	• Finance Report • Performance Report (Q1 2019/20) • Communications Annual Report	• Finance Report • Performance Report (Q2 2019/20)	• Finance Report • Information Governance Annual Report
• CEO Report	• CEO Report	• CEO Report	• CEO Report	• CEO Report	• CEO Report