THE STATE HOSPITALS BOARD FOR SCOTLAND

BOARD MEETING

THURSDAY 26 OCTOBER 2023
at 9.30 am, held in the Boardroom and on MS Teams
A G E N D A

9.30pm			
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 24 August 2023	For Approval	TSH(M)23/07
4.	**Matters Arising:**		
	Actions List: Updates	For Noting	Paper No. 23/89
5.	**Chair's Report**	For Noting	Verbal
6.	**Chief Executive Officer's Report**	For Noting	Verbal
9.50am	**RISK AND RESILIENCE**		
7.	**Corporate Risk Register** Report by the Director of Security, Resilience and Estates	For Decision	Paper No. 23/90
8.	**Infection Prevention and Control Report** Report by the Director of Nursing and Operations	For Noting	Paper No. 23/91
9.	**Bed Capacity Report:** **The State Hospital and Forensic Network** Report by the Medical Director	For Noting	Paper No. 23/92
10.10am	**CLINICAL GOVERNANCE**		
10.	**Clinical Model – Review** Report by the Medical Director and Director of Nursing and Operations	For Noting	Paper No. 23/93
11.	**Medical Appraisal and Revalidation Report** Report by the Medical Director	For Noting	Paper No. 23/94
12.	**Medical Education Report** Report by the Medical Director	For Noting	Paper No. 23/95
13.	**Board approval for Approved Medical Practitioner Status**	For Decision	Paper No. 23/96

	Report by the Head of Planning and Performance		
14.	**Quality Assurance and Quality Improvement** Report by the Head of Planning and Performance	For Noting	Paper No. 23/97
10.50am	**STAFF GOVERNANCE**		
15.	**Staff Governance Report** Report by the Director of Workforce	For Noting	Paper No. 23/98
16.	**Implementation Planning:** **Health and Care Staffing (Scotland) Act and e-Rostering** Report by the Director of Nursing and Operations/ Director of Workforce	For Noting	Paper No. 23/99
11.15am	**** BREAK****		
11.30am	**CORPORATE GOVERNANCE**		
17.	**Digital Inclusion Strategy** Report by the Director of Finance & eHealth	For Noting	Paper No. 23/100
18.	**Planning:** - **Anchor Strategy**	For Decision	Paper No. 23/101
	- **Annual Delivery Plan** Report(s) by the Head of Planning and Performance	For Noting	Paper No. 23/102
19.	**Finance Report to 30 September 2023 (Month 6)** Report by the Director of Finance & eHealth	For Noting	Paper No. 23/103
20.	**Network Information Security – Update** Report by the Director of Finance & eHealth	For Noting	Paper No. 23/104
21.	**eHealth Annual Report** Report by the Director of Finance & eHealth	For Noting	Paper No. 23/105
22.	**Information Governance Annual Report** Report by the Director of Finance & eHealth	For Noting	Paper No. 23/106
23.	**Communications:** **- Annual Report** **- Intranet Upgrade Project** **- Update Report** Report by the Head of Communications	For Noting	Paper No. 23/107 Paper No. 23/108 Paper No. 23/109
24.	**Perimeter Security and Enhanced Internal Security Systems Project** Report by the Director of Security, Resilience and Estates	For Noting	Paper No. 23/110
25.	**Audit and Risk Committee** **Approved Minutes of meeting held 22 June 23**	For Noting	A&R(M) 23/03

	Report of meeting held		Paper No. 23/111
26.	**Any Other Business**		Verbal
27.	**Date of next meeting:** 9.30am on 21 December 2023		Verbal
28.	**Proposal to move into Private Session, to be agreed in accordance with Standing Orders.** Chair	For Approval	Verbal
29.	**Close of Session and Reflection on Meeting**		Verbal

Estimated end at 1pm

THE STATE HOSPITALS BOARD FOR SCOTLAND **TSH (M) 23/07**

Minutes of the meeting of The State Hospitals Board for Scotland held on Thursday 24 August 2023.

This meeting was conducted virtually by way of MS Teams, and commenced at 9.30am

Chair: Brian Moore

Present:

Employee Director	Allan Connor
Non-Executive Director	Stuart Currie
Non-Executive Director	Cathy Fallon
Chief Executive	Gary Jenkins
Director of Nursing and Operations	Karen McCaffrey
Vice Chair	David McConnell
Director of Finance and eHealth	Robin McNaught
Non-Executive Director	Shalinay Raghavan

In attendance:

Head of Communications	Caroline McCarron
Director of Workforce	Linda McGovern
Head of Planning and Performance	Monica Merson
Head of Corporate Governance/Board Secretary	Margaret Smith [Minutes]
Director of Security, Resilience and Estates	David Walker

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

Mr Moore welcomed everyone to the meeting, and apologies were noted from Professor Lindsay Thomson, Medical Director and Ms Pam Radage, Non–Executive Director.

2 CONFLICTS OF INTEREST

There were no conflicts of interest noted in respect of the business on the agenda.

3 MINUTES OF THE PREVIOUS MEETING

The minutes of the previous meeting held on 22 June 2023 were noted to be an accurate record of the meeting subject to minor amendment only.

The Board:

1. Approved the minute of the meeting held on 22 June 2023.

4 ACTION POINTS AND MATTERS ARISING FROM PREVIOUS MEETING

The Board received the action list (Paper No. 23/65) outlining progress on outstanding actions. It was noted in reference to Item 1 that review of carers' clinics would form part of the wider workstream for carer engagement, with reporting to the Clinical Governance Committee. This was being led through the Person Centred Improvement Team.

There were no further matters arising for discussion,

The Board:

1. Noted the updated action list, and confirmed it as being accurate.

5 CHAIR'S REPORT

Mr Moore provided an update to the Board in relation to his activities since the date of the last Board meeting.

He advised that the NHS Chairs Group had met twice, and each occasion included meetings with the Cabinet Secretary for Health and Social Care. An update was provided on the Ministerial Task Force Group on Nursing & Midwifery which included a plan for a Listening Project seeking views from NHS staff. There had been discussion on patient safety and whistleblowing in the context of the high-profile case of Lucy Letby. The Cabinet Secretary had requested that all Boards to revisit whistleblowing arrangements to ensure staff have safe and effective avenues for raising concerns.

Mr Moore described his attendance as a Prevention and Management of Violence and Aggression (Level 3) alongside Ms Radage. They had been able to observe practice in this area, which had been very insightful into the level of preparedness of staff and the skills required in this area. The Chair and Non-Executive Director colleagues had also visited the Control Room to better understand some of the issues in relation to the security project upgrade, and had also had the opportunity to take part in a visit to a ward area to consider the use of seclusion rooms.

On 27 July 2023, Mr Moore attended the Patient Partnership Group where patients received very helpful updates in relation to the Patients' Advocacy Service and the Complaints Service.

Mr Moore advised that on 23 August, both he and Chief Executive had attended a Scottish Government update session on the National Care Service and the proposed shared accountability arrangements and current proposals regarding the establishment of a National Care Board.

The Board:

1. Noted this update from the Chair.

6 CHIEF EXECUTIVE'S REPORT

Mr Jenkins provided an update to the Board on key national issues as well as local updates, since the date of the last Board meeting.

He confirmed that Ms Susan Whyte would join today's meeting in relation to her role as part of the Supporting Healthy Choices team. She had been taking forward work in this area with the team using a QI approach as a refresh to the approach and to progress ambitions. He had also met with Mr David Hamilton, Social Work Mental Health Manager to ensure that TSH is we compliant and aligned to the model for the United Nations Right of the Child, through the Child and Adult Support and Protection work stream.

Mr Jenkins had met with the Minister for Mental Health, Wellbeing and Sport along with the Chief Executive Officers for NHS Greater Glasgow and Clyde, NHS Lothian and NHS Tayside in relation to the provision of female forensic mental health services.

He also highlighted the considerable work ongoing within TSH to prepare for the Network and Information Systems audit, and noted that a further update was included on today's agenda. He underlined the considerable endeavour being made by the security team in relation to some of the recent complexities in the final stages of this project, and that this was on today's agenda. Mr Jenkins thanked the Non-Executive Directors who had been able to attend the site for a visit to the control room and see the complexity of security systems in place at TSH.

Mr Jenkins provided an update regarding the Director of Workforce position. He asked the Board to note that unfortunately, and following a lengthy process, it had not been possible to make an appointment to this post. Therefore, further consideration would now be given as to how to take this forward, and the Board would be kept advised.

Mr Jenkins provided a summary of discussions held in Board Chief Executive (BCE) meetings in July and August. This had included the system pressures and challenges in both elective and unscheduled care. Other items noted included the review of the NHS Resilience Framework, of dental services, and the work progressing nationally on the Agenda for Change pay settlement including a reduction to 36 hours in the working week, a review of Band 5 posts, and protected learning time for staff. The issue of aerated concrete (RAAC) had been raised in terms of the survey of the NHS Estate. Mr Jenkins confirmed that at this stage it did not appear that there was any evident risk in respect to building infrastructure within TSH, but this was being reviewed and further advice would be forthcoming. He confirmed that he had presented to the group in relation to a Women's Service for Scotland on options for the achievability and delivery of some potential models for high secure care. Further, he had presented to the (BCE) ROUP on the Healthcare in Custody workstream, and the way forward. He advised that he continued to lead this with presentation planned for the Scottish Executive Nurse Directors (SEND) group, Medical Directors and to Directors of Public Health, and Board Chairs. Following that Mr Jenkins would host an all day workshop to finalise the ongoing model for Scotland.

Mr Jenkins confirmed that there had also been discussion regarding the Medium Term Plan framework within the BCE Group. The TSH three-year plan had been deferred until the Mental Health and Wellbeing Delivery Plan was published; and further clarification was available in terms of the national direction for forensic mental health.

On a final note, Mr Jenkins noted that the revenue and capital position remained challenging across NHS Scotland. He advised that TSH had not been asked to increase their savings contribution to date, but the commitment remained to delivering value for money.

Mr Currie commented on the need for more certainty for the delivery of forensic mental health services, in terms of the proposed direction of travel as well as resourcing.

Mr Moore thanked Mr Jenkins for this detailed update and the Board noted the position.

The Board:

1. Noted the update from the Chief Executive.

RISK AND RESILIENCE

7 CORPORATE RISK REGISTER

The Board received a paper (Paper No. 23/66) from the Director of Security, Resilience and Estates, which provided an overview of the medium, high and very high risks featuring on the Corporate Risk Register.

Mr Walker presented an overview of the report for the Board, highlighting the movement on risk grading for two risks. The risk relating to "Deliberate leaks for Information" HRD111 had been reviewed and the risk reduced to a medium. Risk HRD112 "Compliance with Mandatory Level 2 PMVA Training" had also been subject to review, and was rated at medium. He also noted that there were three "High" graded risks, down from four since the date of the last Board meeting.

Mr Currie referred to Risk CE14 relating to Covid-19, and the need to encourage staff to take up the offer of vaccination. He asked for confirmation as to whether all TSH staff would be covered in this respect. Ms McCaffrey outlined the measures being taken to monitor the position very closely within TSH, and that front line staff would be included in the vaccination programme. She also advised that in relation to Risk HRD112, work was progressing to ensure that this training was delivered. This had followed the stepping up of the training which required to be delivered face to face following the pandemic, meaning that staff had reached expiry of training at the same time. Mr Jenkins added that analysis had been carried out which had confirmed that there was no correlation to the prevalence of incidents being reported.

Ms Fallon noted the work being developed on risk appetite, and asked for confirmation that this would be brought back to the Board, and suggested it would be helpful to include in a Board Development Session. She added that there the Monitoring Report attached to each paper, was presented in differing levels of details and quality and asked for focus on this in the future.

Action(s) – Ms Smith

Mr Moore added that it would be helpful to get reporting on the Local Risk Register included in this report. He also asked for consideration as to how each risk was being monitored, so that consistency of approach could be demonstrated.

Actions(s) – Mr Walker

The Board:

1. The Board reviewed the current Corporate Risk Register and approved it as an accurate statement of risk.
2. Requested an update on risk appetite to the Board, through a Development Session
3. Requested changes to reporting to demonstrate how risks were monitored, as well as to add updates on Local Risk Registers.
4. Asked for Monitoring Reports to be reviewed across all Board reporting.

8 INFECTION PREVENTION AND CONTROL REPORT

The Board received a paper (Paper No. 23/67) from the Director of Nursing and Operations, and Ms McCaffrey summarised the content of the report.

She confirmed that there had been no areas of concern escalated from the Infection Control Committee and provided a summary of activity around hand hygiene with noting that although some improvement had been seen, and acknowledging further focus was required to improve compliance levels.

In relation to Covid-19, she asked the Board to note that there was a small number of cases within one ward, managed through existing practice. In terms of national healthcare associated infection (HCAI) strategy, the current two-year period would be used to provide a baseline position to help inform a five-year strategy for the period 2025/30.

Mr Currie asked whether the risk of un-vaccinated visitors coming into the hospital had been considered, especially since visitors may not be covered by the general public criteria for vaccination. Ms McCaffrey confirmed that careful advice is provided to all visitors, in terms of coming into the hospital and at present face masks had been added for use by staff within the security reception, but there was no indication for any wider changes at this point.

In answer to a question from Mr Moore in respect of whether the hand hygiene risk was joined up to the Occupational Health Service, Ms McCaffrey confirmed that this was the case and work would continue in this regard.

The Board:

1. Noted the content of report.

9 BED CAPACITY REPORT

The Board received a paper (Paper No. 23/68) from the Medical Director, which detailed the actions taken to monitor the bed capacity within TSH as well as impacts from the wider Forensic Network. In the absence of Professor Thomson, Ms McCaffrey summarised the detail of the report for the Board, and placed this within the context of the operating model within TSH, which was tight but manageable in terms of delivery care.

Ms Fallon asked about the two patients indicated to be waiting in excess of a year to transfer, and noted reporting should also include the unit that patents were awaiting transfer to. She also asked for clarification on how clinical activity at medium secure units may impact their ability to admit patients. On the second question, Ms McCaffrey outlined the way in which increased clinical activity can mean that more staffing resources were required impacting the ability to accept a patient. Mr Jenkins added that in addition female patients within medium secure within Rowanbank may require high levels of observation due to the lack of seclusion suite. He confirmed that a further update would be provided on the two patients awaiting transfer, and would be fed back to Non-Executives Directors.

Action – Mr Jenkins/ Dr Alcock

Mr Moore summarised for the Board, in terms of the importance of this report to demonstrate the flow of patient transfers, and that there was a significant number of patients within TSH waiting to move.

The Board:

1. Noted the content of report.
2. Noted the continued pressures across the forensic estate, and further detail on waiting times/ where patients were awaiting transfer.
3. Update on patients awaiting in excess of a year to transfer.

CLINICAL GOVERNANCE

10 PATIENT STORY

The Board received a presentation in the form of a recording from a current patient, talking about his experience within the hospital.

The Board was joined by Ms Garrity, who noted that she had recently taken up leadership of the Person Centred Improvement Team. This team had supported the patient to tell his story. Ms Garrity explained that the patient had been admitted to the hospital a few months prior to the implementation of the new clinical model, and had been clinically assessed to be in the admissions service.

The Board then heard a recording of the patient telling his story – he felt that from his perspective he was concerned that he should not have been placed in an admissions ward; and that he should have been placed in a transitions ward. He felt that he had some mixed messages from staff in this regard. He did think that there were good things about being in an admissions ward; but he also felt he was being left behind when he saw other patients being moved on. He said he was worried about whether this meant he was not getting therapeutically aligned care centred based on his own needs. He was

concerned that this was due to bed capacity rather than his clinical status. The patient offered the view

that he thought that some staff may also find that it would be difficult to deliver the right care for him. He also thought he was a lot further on in his care than other patients in the ward.

Mr Moore commented that it was good to hear directly from an individual patient about his views to give the Board this insight within the overall principles of the model especially progression for patients. Mr Jenkins agreed and noted that all patients had undergone clinical risk assessment, to place them in the right service. This had been repeated to ensure it was up to date following the pause due to incidence of Covid-19. He offered the view that it was not optimal for a patient to feel worried that his care was impacted by bed capacity within the hospital as this was not the case, and staff locally should be able to reassure the patient about this.

Ms McCaffrey picked up this point confirming that all patients were robustly assessed to ensure that they were placed within the right service based on individual need. There would be a broad spectrum of patients within each service, in terms of the stage they were each at in terms of their care. She added that this story was brought to the Board to show the individual perception of a patient that may not always be wholly positive.

Mr McConnell asked if there had been wider commonality across patients; with more re-categorisation required. Ms McCaffrey advised that there was continual assessment made for each patient, and conversations should be ongoing with each around how they would make to the next stage to enable planned transitional points. Ms Garrity added her agreement to this especially around the involvement of the clinical teams. She added that this patient had now been assessed as ready to move on to the transitions service.

Ms Fallon voiced her thanks to the patient for being willing to tell his story in this way, and thought this did demonstrate his trust and confidence in staff that he had been willing to do so. She asked also asked whether there had been any mechanism to get staff views on the new model, and Mr Connor advised that he thought that it was still too early in the process to get clear ideas on this. Mr Currie commented that it may be difficult to manage patient expectations, and this story did act to help challenge the Board to have this discussion and take what the patient had to say seriously. It offered a helpful insight into what patients and staff were feeling.

Ms McCaffrey thought the approach was crucial, and patient feedback demonstrated a desire to be able to link directly to the Board. It was essential that patients felt confident enough to voice their views and feel that they were being listened to by the organisation. She also gave assurance that staff would respond to concerns raised by patients immediately.

Mr Jenkins noted that it was essential to make sure that there was no ambiguity in messaging from staff to patients as this would not be helpful for the patient, as had appeared to be the case here. The concern was if the patient had a misperception about his assessment. He confirmed the careful assessment carried out for each patient and that the right level of data on this could be made available to the Board.

Action – Mr Jenkins/Dr Alcock

Mr Moore noted that the Board welcomed the opportunity to hear patient stories, and it was confirmed that Ms Garrity would provide this feedback to the patient as well as to the Patient Partnership Group.

<u>The Board:</u>

1. Noted the content of presentation.
2. Thanked the patient for his contribution
3. Confirmed the Board will get update on data in respect of patient assessment.

11 IMPLEMENTATION OF SPECIFIED PERSONS – 12 MONTH REPORT

The Board received a paper (Paper No. 23/69) from the Director of Security, Resilience and Estates, to

submit annual reporting on the implementation of regulations relating to the safety and security, use of telephones and correspondence on the part of patients within TSH, under the Mental Health (Care and Treatment (Scotland) Act 2003. Mr Walker presented the paper to the Board, outlining the restrictions relating to "specified persons" which supported the safety and welfare of the patient and others by allowing the clinical team to manage controls proportionately in defined areas. He highlighted the increase in the items of withheld mail within the reporting timeline, and provided further clarification that this was related to two patients and their preference to limit contact with identified individuals, outwith the hospital.

Ms Fallon commented that patient incidents and restrictions were reported in detail quarterly to the Clinical Governance Committee, and that it may be helpful to link to the legislative framework to give the required assurance that all responsibilities were being met. Mr Jenkins picked up on this point and agreed it would be helpful to circulate further guidance.

Action – Mr Jenkins/Dr Alcock

Mr McConnell referred to discussion within the PPG, which were about the ability to access telephone calls rather than supervision of calls, which patients appeared to understand and accept. He asked if the move to a new telephone system would assist in that regard. Mr Walker advised that the options appraisal was being taken forward presently but was focused on the operational aspects of the system rather than management within wards. However, reporting could be provided to the Clinical Governance Committee to encompass these points.

Action – Mr Walker

The Board:

1. Noted the content of the report
2. Requested further guidance on the link to legislative framework
3. Noted that further reporting on the options appraisal for the telephone system, and use of telephones would be submitted to the Clinical Governance Committee.

12 CLINICAL MODEL - UPDATE

The Board received a paper (Paper No. 23/70) from the Medical Director, to provide an update on the clinical model implementation which was now business as usual for the delivery of care within the hospital.

Ms Clark joined the meeting and provided a high level summary on the activities of the Clinical Model Oversight Group, and how this linked to the Service Leadership Teams. She indicated that given that clinical guidance to support the model had gone live on 24 July, there was not yet a sufficient period of evaluation to measure and report significant changes.

Ms Fallon noted that there had been a helpful and detailed discussion round the clinical guidance at the Clinical Governance Committee this month, and asked of there had been any obstacles or delay in the setting up of each Service Leadership Team. Ms Clark provided assurance that services were currently arranging schedules for formal meetings, and that this was well underway.

Mr Moore summarised the discussion, and noted that the Board were content to receive this update with further detailed reporting being submitted to both the Clinical Governance Committee and the Staff Governance Committee at their next meetings. The Board had considered the recommendation on reporting direct to the Board, and were in agreement that this should continue at this stage.

The Board:

1. Noted the content of this update.
2. Agreed further reporting to evaluate the model should return directly to the Board.

13 SUPPORTING HEALTHY CHOICES

The Board received a paper (Paper No. 23/71) from the Medical Director, to provide an overview of the Supporting Healthy Choices (SHC) Improvement Programme, outlining the focus on improving patients' physical wellbeing and reducing levels of obesity. Ms Whyte joined the meeting to summarise the report for the Board, and to provide further background on the activities of the programme.

She highlighted the way in which her appointment as improvement lead would help to focus the aims of the group, as well as the widening membership of the dedicated team. She noted the need to fully understand the baseline position, and set a measurement plan to help inform the improvement routes and review of the driver diagram. She advised that it would be essential for the team to consider individual patient circumstances within the context of their stage or phase of care. It would also be important to consider impacts from daytime confinement, as well as engaging widely with staff as well.

Ms Fallon asked whether more background information could be provided on the comparison of the management of obesity on other high secure hospital settings, as well as on the position on access to the Turas system, and that a dietetic post (band 5) was no longer in place. She added that it would be helpful to add this workstream to the Clinical Governance Committee Workplan for detailed oversight.

Action – Ms Smith

Ms McCaffrey commented on the collaborative approach being taken across high secure hospitals, linking with colleagues in NHS England to do so, and share learning. This was in progress and would be fed into this workstream. Ms Whyte confirmed that the impact of the reduction in dietetic resource was being closely monitored and any identified gap being worked around. On the point on Turas access, it was agreed that this should be explored further to confirm what it related to and an update provided.

Action – Ms Whyte

Mr Moore noted that the Key Performance Indicator (KPI) for management of obesity had been under consideration in terms of whether the right approach was being taken in what was a very complex area. Ms Whyte commented that taking an improvement approach looking at change may be helpful although this would take time to see meaningful measurement data. Ms Merson underlined the importance of setting achievable and realistic targets, which would demonstrate improvement. This could be informed by looking at how targets on this area were set across all forensic services. Mr Jenkins noted that the improvement approach being led by Ms Whyte should harvest more meaningful trajectory of data across patient groups. This was a challenge that should be seen within the wider population health challenge facing society as a whole, and deprivation indicators. He referred to the possibility of the addition of further academic research in this regard, to help support the SHC team.

Mr Moore thanked Ms Whyte for joining the meeting and for providing this update, in what was a key area of concern for the Board.

The Board:

1. Noted the content of this update.
2. Requested update on Turas issue, and reporting to the Clinical Governance Committee.

14 CENTRALISED VISITNG – REVIEW

The Board received a paper (Paper No. 23/72) from the Director of Nursing and Operations, to provide an update on the impacts of the revised centralised visiting process on patients and carers. Ms Garrity

joined the meeting to provide an overview of this. She highlighted the positive nature of the feedback received to date, especially from carers. At the same time, some frustration had been expressed on the delays being experienced in getting access to the new garden area due to awaiting installation of new fencing. Further, feedback had indicated that being able to bring light refreshments to the centre to be

consumed during the visit was also seen as being beneficial by patients and carers. Ms Garrity explained that this was under review presently. Finally, she explained that there had been some negative feedback around delays to the start of visits within the centre, and this was also under review, including an audit of the reasons for delays, to ensure improvement could be made.

Following Ms Garrity's summary, it was confirmed that the fencing for the garden area was a priority and this would be expedited by the Head of Estates and Faculties.

Action – Mr Walker

Mr Connor asked if visiting was now seven days a week, and Ms Garrity advised that visits took place on every day except Mondays, and that this included weekend periods. Visiting was planned to ensure that the needs of carers were also taken into account including the distance that they had to travel to get to the hospital. She added that child visits usually took place on weekends, but some did take place midweek.
A clear benefit of the new process was the way in which the Person Centred Improvement Team had become familiar and knowledgeable about the needs of carers to try to make the visiting process as smooth as possible. On the point about foodstuffs being brought to visits, Ms McCaffrey noted that this had required policy change as well as consideration by the Infection Control Committee, and confirmed that this was now being finalised.

Mr Moore summarised for the Board, saying that it was clear that assurance could be taken that the visiting experience had improved; and that the consistency of approach being taken was positive.

The Board:

1. Noted the content of this update.

15 QUALITY ASSURANCE AND QUALITY IMPROVEMENT

The Board received a paper from the Head of Planning and Performance (Paper No. 23/73) which provided update reporting on progress made towards quality assurance and improvement activities since the date of the last Board meeting.

Ms Merson summarised the key features of the report confirming that clinical audit work had restarted following the implementation of the clinical model changes. She detailed the main points of the flash report on variance analysis tools which had been updated to taken into account the new clinical service areas, and demonstrating VAT completion of 98% for the month of June. She also noted the detail of the Clinical Quality flash report, which showed the steady increase in timetabled activity sessions, and an overall decline in the number of incidents. At the same time, the report also showed an increase in the number of patients with no physical activity. The number of patients with no access to fresh air had decreased which was positive.

Ms Merson also summarised the work progressing through the QI Forum, and QI Capacity Building with the aim of holding a new round of TSH3030. She summarised the six key themes and action plan being taken forward through the Realistic Medicine workstream. Finally, she summed up the activity progressed through the process in place for evaluating national and local guidelines within a quality framework, and for relevancy to TSH.

Ms Fallon asked for feedback on the Clinical Quality Strategy, and also suggested that more specific target dates were included in the evaluation matrix particularly given that some of these had been in place for a long time. It was agreed that information should be added as to why projects were running

late, specific to each case. Ms Merson confirmed that there was a need to progress the Clinical Quality Strategy, and that this would be taken forward.

Action (s) – Ms Merson

Mr McConnell asked if there was anything substantive to flag from the guidance from NHS England (Managing a Healthy Weight in Adult Secure Services) in relation to the approach being taken locally through Supporting Healthy Choices. Ms Merson noted that this was a very comprehensive

document which required further review – this was an area of focus and a further progress update would be brought back through reporting.

Mr Moore noted the positive improvement in terms of patient access to fresh air, whilst this was mixed with an increase with the number of patients with no access to activity. He commented that it would be good to see the return of the TSH 3030 initiative for quality improvement projects. Finally, that as discussed in relation to the evaluation matrix, more narrative about why completion was being delayed and target dates for this, and to place this within the relevance to TSH.

The Board noted the content of the report, and the level of assurance it provided.

The Board:

1. Noted the content the report and updates contained therein.
2. Requested detailed narrative within evaluation matrix on reasons for delay, time expected to completes, and relevance to TSH.
3. Noted requirement to progress the Clinical Quality Strategy and that reporting would return to the Board.

16 CLINICAL GOVERNANCE COMMITTEE

The Board received the approved minutes from the meeting that took place on 11 May 2023, as well as summary reporting of key item discussed at the meeting that took place on 10 August 2023. It was noted that this was a new type of reporting for the Board and would be received at the next Board meeting following each governance committee meeting.

The Board:

1. Noted the approved minutes of the meeting of the Clinical Governance Committee that took place on 11 May 2023.
2. Noted the content of the summary report of the key points of discussion at the Clinical Governance Committee which took place on 10 August 2023.

STAFF GOVERNANCE

17 STAFF GOVERNANCE UPDATE REPORT

The Board received a report from the Director of Workforce (Paper No. 23/75) to provide an update on all aspects of workforce performance across a range of key performance indicators (KPIs). Ms McGovern provided an overview of the key points of the report, highlighting the focus on attendance management through a Task and Finish Group set up to lead on improvement on rates of sickness absence. She also provided an update in relation the range of metrics included within the report, noting that these had been subject of detailed discussion at the most recent meeting of the Staff Governance Committee.

Ms Fallon noted that although there were a number of positives in the report; there were also some areas of concern most particularly management of sickness absence and that the job evaluation process was acting as an obstacle to progressing recruitment. She asked for clarification as to when

evaluation of the use of temporary placements and/or reasonable adjustments would be available. Ms McGovern advised that feedback on this would be brought to the next meeting, as well to the Staff Governance Committee.

Mr Moore noted that this report covered a range of items; with detailed oversight taken through the Staff Governance Committee and that this was shown through the update from the committee on today's agenda.

The Board:

1. Noted the content of the report

18 IMPLEMENTATION PLANNING – HEALTH AND CARE STAFFING (SCOTLAND) ACT/ E-ROSTERING

The Board received a report from the Director of Nursing and Operations and the Director Workforce (Paper No. 23/76) which outlined the process for implementation of e-rostering as well as the early implementation and testing of aspects of the Health and Care Staffing (Scotland) Act 2019 (the Act) .

Ms McCaffrey provided some background in terms of the aim of the Act and the rationale for TSH being an early implementer, and the benefits being realised through doing so, particularly in sharing learning with other Boards. She described the way on which this was being progressed through a project team, the progress made to date, and how oversight of this was being led through management reporting structures. She underlined that the implementation of e-rostering was separate to preparation for the Act, but that this was clearly linked and supported its aims.

Mr Moore asked about whether there had been opportunities for learning for TSH so far during the roll out of the testing of aspects of the Act; and Ms McCaffrey confirmed that this had been the case, as well as the process providing reassurance for TSH in terms of preparedness. To date, the TSH team had found that they were able to provide learning to other Boards. In answer to a query from Ms Fallon about the two additional posts to support e-rostering, Ms McGovern confirmed that the recruitment process was underway and these posts would be filled shortly. Mr Jenkins clarified that funding for these posts had been found within existing TSH budgeting, in view of the importance of compliance with the legislation,

Mr Moore summarised the discussion, with the Board taking assurance from reporting to date; and also requesting further updates in this respect at each Board meeting, as well as at the next Board Development session scheduled to take place on 7 September 2023.

The Board:

1. Noted the content of this update;
2. Noted that the Board would receive a further detailed update at the development session on 7 September.

19 WHISTLEBLOWING- QUASTER 1 REPORT 2023/24

The Board received a report from the Director Workforce (Paper No. 23/77) which provided quarterly reporting in respect of whistleblowing cases raised within this period. Ms McGovern confirmed that no new cases had been received during this quarter. She also provided an update on preparation for "Speak Up" week at TSH, which would take place on week beginning 2 October 2023.

Mr Moore commented on the need to prepare for this, to enable a stronger focus in this area to give staff confidence in raising concerns. Ms Raghavan noted that this would be a good springboard for her to cement her role as Whistleblowing Champion in TSH, and also of retaining the focus on supporting

staff to raise concerns going forward. Mr Moore agreed that there should be regular communications in this regard, and Ms McCarron suggested that video links could be used to promote the role of Whistleblowing Champion.

The Board:

1. Noted the content of the report

20 STAFF GOVERNANCE COMMITTEE

The Board received the approved minutes from the meeting that took place on 18 May 2023, and the report of the meeting that took place on 17 August, confirming that this was a helpful addition to reporting.

The Board:

1. Noted the approved minutes of the meeting of the Staff Governance Committee that took place on 18 May 2023.
2. Noted the summary overview report on the key points of discussion of the meeting that took place on 17 August 2023.

CORPORATE GOVERNANCE

21 FINANCE REPORT 10 31 JULY 2023 (MONTH 4)

The Board received a paper (Paper No. 23/79) from the Finance and eHealth Director, which presented the financial position to 31 July 2023, reporting on both revenue and capital resource spending and the projected yearend financial outturn. Mr McNaught summarised reporting, noting that the Board was reporting a small overspend at this date, with spending on its planned trajectory for the year.

He confirmed that directorate budget reviews for the current year were agreed with regard to individual budgets and savings plans, and that focus was now on addressing how these will be phased through the remainder of the year. He confirmed that there had been communication from government with all National Boards in respect of in-year allocations and reductions thereto, and the possibility of review of delivery of services to provide additional savings from in year allocations. He also noted that the capital resource budget, which was fully utilised for 2022/23, had been set for 2023/24. The budget was expected to be fully utilised, with focus on capital demands for the next five-year period to ensure priorities were identified.

Mr Currie commented on the need for change across NHS Scotland, and how to effect this with a view to achieving the required levels of savings; the difficulty being changing outcomes within the existing framework. Mr McNaught noted the need for focus on longer term financial planning, and that the intent was to do so for a five-year period.

In response to queries from Ms Fallon on Pay As If At Work (PAIAW) and cross-charging arrangements for exceptional circumstance patients, Mr McNaught advised that the monies due to be paid to TSH for cross charging was being pursued, but remained outstanding. PAIAW costs were being addressed as they arose, and did not present concern. Mr McConnell asked about what an additional savings request to National Boards would look like for TSH in terms of proportion of in year funding allocations. He noted his agreement to the principle of prudence with year end projection for a small underspend. Mr McNaught confirmed that for TSH additional allocations were for specific items and allocated to a specified budget and this tended to be smaller in scale; and this differed from the position in some other boards where in year allocations could be more general in nature and of a more significant amount.

Mr Moore summarised for the Board, noting the draft budget for the current year and challenging position in this respect.

The Board:

1. Noted the content of the report.

22 NETWORK INFORMATION SYTEMS REPORT

The Board received a paper (Paper No. 23/80) from the Finance and eHealth Director, to provide a detailed update on the work being progressed in this area. Mr McNaught summarised the main aspects, confirming that addressing the specific NIS measures was well underway through individual directorate responsibilities. Progress was being tracked fortnightly with any outstanding evidence being prepared for submission by August prior to the external appraisal scheduled in October. He advised that the independent reviewer undertook a site visit at TSH which enabled a fuller appraisal of the physical aspects of the TSH site and systems and to help to demonstrate physically a number of areas of compliance.

It was noted that after the 2023 review and issue of the results, the Competent Authority who undertake the review would require a meeting on site with the Board to discuss the outcome, and that this had scheduled for 6 December.

Mr Moore noted the progress being made in this area, and that a further update would come to the next Board meeting, and that thereafter the Board would receive feedback directly from the Competent Authority.

The Board:

1. Noted the content of the report.

23 PERIMETER SECURITY AND ENHANCED INTERNAL SECURITY SYSTEMS PROJECT

The Board received a report from the Director of Security, Resilience and Estates (Paper No. 23/81) detailing the update of the Perimeter Security and Enhanced Internal Security Systems re-fresh project. Mr Walker highlighted the key points, and the Board noted that a further update would be presented in a private session of the Board, given the security and commercial sensitivities.

The Board:

1. Noted this update in relation to the perimeter Security and Enhanced Internal Security Systems Project and recognised that this was a feature within the Private Session of the Board Meeting.

24 PERFORMANCE: QUARTER 1 REPORT 2023/24

The Board received a paper (Paper No. 23/82) from the Head of Planning and Performance to provide a high-level summary of organisational performance for Quarter 1 of the current financial year. She highlighted that there were five key performance indicators (KPIs) which were off target for this period. There had been a small decrease in performance for review of care and treatment plans at six month intervals. In relation to engagement in psychological therapy, this was multi-factorial but staffing resourcing had been impactful during this period. Ms Merson noted the change in the way that the KPI for physical activity was measured, from the start of this quarter; and that the Board had received assurance reporting separately as part of today's agenda in relation to the actions being taken to improve the position on patient obesity. She noted that in terms of sickness absence, performance continued to be off target and that a Task and Finish Group had been stood up to take oversight and directly lead improvement in this area through a range of interventions.

The Board was content to note this detailed update and the information provided as part of reporting, and through Ms Merson's overview. Mr Moore noted that reporting helped to demonstrate the benefit of the GP service provided.

The Board:

1. Noted the content of the report.

25 COMPLAINTS ANNUAL REPORT 2022/23

The Board received a report from the Head of Corporate Governance (Paper No. 23/83) which outlined complaints activity during 2022/23. Ms Smith led the Board through a high level summary of the report, emphasising the way in which the issues raised through the complaints process can help to inform learning and make improvements. She asked the Board to note the main themes especially around staff attitude and behaviour and communications, which showed how important relational aspects were in care delivery within TSH. She noted that it was also important to look at the recurring issues raised, in terms of whether the outcome was upheld or not. Whist the majority of complaints relating to clinical treatment and staff attitude and behaviour were not upheld; the majority of those relating to communications had been upheld and this was an area for focus in terms of improvement actions.

Mr Currie said that it would be important to focus on those areas where similar issues recurred over time in terms of whether learning was being taken. He added that the number of complaints investigated and upheld in whole or part did help to promote perception of fairness within the system and that concerns raised would be taken seriously. In response to a query from Mr Moore on where the Scottish Mediation Service could have a role, Ms Smith advised the background to this within TSH. This could be helpful to support care being delivered over the long term where the relationship between a patient or carer, and the clinical team may benefit from more structured support that wouldn't form part of the complaints process itself.

Mr Moore summed up for the Board, noting that value of this reporting for quality assurance in delivery of the complaints service, and that the structure and content of it was helpful. He thanked Ms Smith and her team for the report, and their work in this area. He added that it was reassuring to see the close involvement of the Patient Advocacy Service in supporting patients to make complaints.

The Board:

1. Noted the content of the report.

26 BOARD PLAN – MEETING SCHEDULE 2024

The Board received a report from the Head of Corporate Governance (Paper No. 23/84) to set the schedule of Board and Committee meetings for 2024.

The Board:

1. Noted the proposed Schedule which was approved in principle, subject to any required minor changes.

27 ANY OTHER BUSINESS

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

28 DATE AND TIME OF NEXT MEETING

The next public meeting would take place at 9.30am on Thursday 27 October 2023.

29 PROPOSAL TO MOVE TO PRIVATE SESSION

The Board then considered and approved 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.

30 CLOSE OF MEETING

The meeting ended at 1.20pm

ADOPTED BY THE BOARD _____

CHAIR _____

DATE _____

NHS SCOTLAND

THE STATE HOSPITALS BOARD FOR SCOTLAND
ROLLING ACTION LIST

ACTION NO	MEETING DATE	ITEM	ACTION POINT	LEAD	TIMESCALE	STATUS
1	April 2022	QA and QI	Update on Carer's clinic workstream	Monica Merson	To be Closed	Update June 2022: Progress with clinic in 2 Hubs during Feb – May 2022. Given positive feedback, further clinics will be held on 3-monthly basis. Feedback Reporting to be prepared end of November, and then update back to the Board planned for December meeting. **Update December:** This is part of Realistic Medicine Update – Completion of four clinics at a minimum required before detailed assessment could be undertaken, timing of final clinical was at end of November and work is underway and not yet complete. This should return to the Board as part of QA/QI report. **Update: February 2023:** Delayed update due to vacancy arising in project manager role, this is being reviewed by Head of Planning & Performance. **Update April 2023**: redeployed nursing resource temporarily in place to support Realistic Medicine, and update to next Board meeting. PCIT aware of this workstream, but no direct involvement. **Update June 2023:** update to Clinical Governance Committee provided in May 2023: further clinics paused until end of clinical model moves, and then reviewed. **August 2023**: Reviewed at Clinical Governance Committee – to be included in overall carer strategy in future. Consider closing on this action list. Remitted to Clinical Governance Committee – close action **CLOSED**

2	Feb 23	Workforce Report	More detailed exploration of trends /patterns of sickness absence – add profile of length of service as well as service area. Add longitudinal data	L McGovern	To be updated October 23	**Update April 2023:** Reporting reviewed and presented under new format and including areas highlighted. Board reviewed changes in reporting and asked for further development of themes for sickness absence which would also be reviewed at Staff Governance Committee. **Update June 2023:** Reviewed by Board and further assurance reporting to be presented to Staff Governance Committee in August 23. **October 2023:** Reporting on agenda,
3	August 23	Corporate Risk Register	General request that monitoring reports are updated in details across all reporting	M Smith	October 23	**Update October 23:** Highlighted in board update to the CMT, following the Board. All sponsoring directors asked to ensure that report authors complete the form, and director to sign off.
4	August 23	Corporate Risk Register	Include local risk register in reporting to align and tie together with CRR	D Walker	October 23	**Update October 23:** update is included in reporting on agenda
5	August 23	Bed Capacity	Include the unit patient to be transferred to , as well as time waiting	L Thomson	October 23	**Update October 23:**This is in additional to previous request re adding time awaited to transfer – included in reporting on agenda
6	August 23	Patient Story	Background data for Board on how the patient assessments were taken forward for placement within clinical model	L Thomson/ K McCaffrey	October 23	**Update October 23:** Two desktop exercises were held where RMOs and clinical teams were given definitions of each of the 4 services and asked to place each patients accordingly. Some anomalies were found during these exercises, for example a patient placed in transitions who had not been referred for transfer. The third exercise was used to place patients and reference back to clinical teams and to patients made to ensure this was done sensitively.
7	August 23	Specified Persons	Re legislative aspects linked to restrictions – background reporting on forensic mental	L Thomson	TBC	**Update October 23:** Verbal update will be provided at Board meeting

			health framework			
8	August 23	Specified Persons	Update to CGC re the telephone system and management of tel calls	D Walker	November	**Update October 23:** Added to November Agenda of Clinical Governance Committee –close
9	August 23	Supporting Healthy Choices	Add to CGC for reporting Update on Turas issues reported on	L Thomson/ M Smith/ S Whyte	TBC	**Update October 2023:** CGC Workplan to be updated and date for reporting to CGC to be confirmed. **Update October 23:** Confirmed that TSH staff have ongoing problems with access and that TURAS are aware of and are trying to resolve Below is text from the funding letter re the use of TURAS. *Boards must continue to record **all** referrals to weight management and type 2 diabetes prevention and remission services using the agreed standardised core dataset as stipulated by the 2023-24 Framework milestones in the implementation plan and gap analysis. Once fully integrated on to the Turas platform, boards must use this platform to continue to collect data and provide reporting to PHS.* *SHCIP added to the CGG to meet the schedule that is set the Committee.*
10	August 23	Central visiting / family centre	Update on fencing – when installed and gardens available	D Walker	October 23	**Update October 23:** Update on installation date to be provided at Board meeting

11	August 23	QA/QI	Update on Clinical Quality Strategy, narrative within evaluation matrix on delays as well as target dates	M Merson	October 23	**Update October 23:** Update below is included in the QA/QI Paper on agenda. TSH will revise the Quality Strategy in 2023/24 with initial scoping taking place. In relation to the evaluation matrix a column has been added to the table on target completion dates and included text in the updates on current position so if there are any delays these are explained

Last updated – 26.10.23 – L. Kirk

Author:
Margaret Smith
Head of Corporate Governance 01555 842012

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	26 October 2023
Agenda Reference:	Item No: 7
Sponsoring Director:	Director of Security, Estates and Resilience
Author(s):	Risk Manager
Title of Report:	Corporate Risk Register Update
Purpose of Report:	For Decision

1 SITUATION

A corporate risk is a potential or actual event that:

- Has potential to interfere with achievement of a corporate objective / target; or
- If effective controls were not in place, would have extreme impact; or
- Is operational in nature but cannot be mitigated to the residual risk level of Medium (i.e. awareness needs to be escalated from an operational group)

This report provides the Board with an update on the current Corporate Risk Register.

2 BACKGROUND

Each corporate risk has a nominated executive director who is accountable for that risk, as well as a nominated manager who is responsible for ensuring adequate control measures are implemented.

3 ASSESSMENT

3.1 Current Corporate Risk Register - See appendix 1.

3.2 Out of Date Risks

All risks are in date.

3.3 Update on Proposed Risks for inclusion on Corporate Risk Register

HR
HR have developed a risk assessment relating to the impact of delays within the job evaluation process and the potential impact this may have on services. The risk assessment details the control measures in place to minimise the impact of this process as well as ongoing work that is underway to mitigate the risk further. The risk has been added to the Corporate Risk Register and is currently graded at Moderate x Possible giving an overall rating of Medium. Full risk assessment is available in Appendix 2.

3.4 Corporate Risk Register Updates

Director of HR and Wellbeing: HRD112 – Compliance with Mandatory Level 2 PMVA Training
Training plan was successful delivered and training figures are again exceeding the 90% target. Risk grading has been reduced again to Moderate x Rare giving an overall rating of Low. The learning centre are aware that this could potentially be a recurring theme as a large number of staff may be due renewals at once, to combat this refresher training will aim to be spread out over the year to mitigate the risk of compliance levels dropping again.

3.5 High and Very High Risk – Monthly Update

The State Hospital currently has **3** 'High' graded risks:

Director of Nursing: ND71 - **Failure to assess and manage the risk of aggression and violence effectively**
Risk is at target level and continues to be managed effectively with existing procedures and training. Violence and aggression incidents monitored by Risk & Resilience Team through Clinical Governance Group.

Monthly Update: Violent incidents remain similar in Q2. PMVA Level 2 Figures are now exceeding target of 90%. No RIDDORs reported in Q2. Work is underway to update risk assessment with a focus on 'Serious' violent incidents and the risk to staff. This will allow us to reduce the level of risk to Medium.

Medical Director: MD30- Failure to prevent/mitigate obesity.

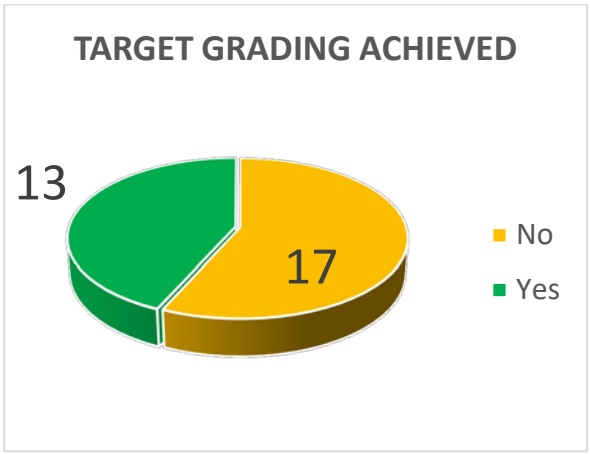
Monthly Update: : Overweight and obesity in Sept '23 was 80.7% slight Decrease from 86.7% however missing data was greater at 8.7% compared to 5.7% last report.

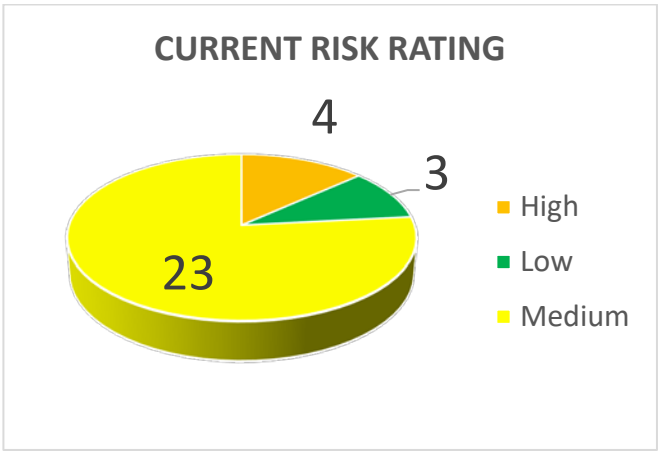
The Supporting Healthy Choices project team are progressing well with a QI approach to implementing developments in this area to improve health. The SHC meet on the 15th September to plan the way forward with the current actions. Work on projects and groups to follow. Awaiting further updates from team when they return from annual leave.

Nursing Director: ND70: Failure to utilise our resources to optimise excellent patient care and experience.

Monthly Update: Implementation of E-Rostering continues across the hospital; Full time project manager has been appointed to complete the rollout of the project. Next meetings have been scheduled. Activity being monitored regularly with reports going to several groups within the hospital with oversight in place from the Activity Oversight Group.

3.6 Risk Distribution





Currently 13 Corporate Risks have achieved their target grading, with 17 currently not at target level. 1 risk has been reduced since the last report from Medium to Low (HRD112).

As per the TSH Risk Management Strategy, Low and Medium risks are tolerated within the organisation's risk appetite. While some of the Corporate Risks have not met their target level, they still remain within the agreed risk parameters. Ongoing work is underway to reduce risks to target level by the Risk Management Facilitator, risks are reviewed continuously and updated where required.

	Negligible	Minor	Moderate	Major	Extreme
Almost Certain					
Likely		CE14	ND70,	MD30,	
Possible			CE12, SD57, FD91, ND73, FD99. HRD113	ND71	
Unlikely			MD33, FD90, HRD110, FD96, FD98	MD34, SD51, SD50, SD54, HRD111	
Rare			FD97, CE13, SD52, HRD112	MD32, SD56,	CE10, CE11, SD53, CE15

Review Periods:

Low risk	6 monthly
Medium risk	Quarterly
High risk	Monthly

Very High	Monthly (or more frequent if required)

3.7 Local Risk Registers
As part of the overall Risk Management Strategy, TSH has created and manages a suite of Local Risks. There are a total seventy six medium and low risks each managed by the respective Head of Department.

The Risk team oversee the process and report quarterly to the Organisational Management team. Where information or data highlights a change to the risk profile, the risk will be presented to OMT and consideration given to any additional control measures required to achieve target level. If appropriate OMT will consider escalation to CMT for inclusion in the Corporate Risk Register.

The LRR process is paper based and will transfer to the Datix system in early 2024.

3.8
3.9 CRR Development
The Risk management team are continuing to review and refresh the risk management process and a proposal on a new approach will be submitted for discussion at the next Board development session on 7 November 2023. This is a follow up to the Board Development session on its risk appetite.

4 RECOMMENDATION

The Board are asked to note the process for managing Local Risks and review the current Corporate Risk Register as an accurate statement of risk.

MONITORING FORM

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

High Risks

Ref No.	Category	Risk	Initial Risk Grading	Current Risk Grading	Target Risk Grading	Owner	Action officer	Next Scheduled Review	Governance Committee	Monitoring Frequency	Movement Since Last Report
Corporate MD 30	Medical	Failure to prevent/mitigate obesity	Major x Likely	Major x Likely	Moderate x Unlikely	Medical Director	Lead Dietitian	27/10/23	Clinical Governance Committee	Monthly	-
Corporate ND 70	Service/Business Disruption	Failure to utilise our resources to optimise excellent patient care and experience	Moderate x Possible	Moderate x Likely	Minor x Unlikely	Director of Nursing & AHP	Director of Nursing & AHP	16/11/23	Clinical Governance Committee	Monthly	-
Corporate ND 71	Health & Safety	Failure to assess and manage the risk of aggression and violence effectively	Major x Possible	Major x Possible	Major x Possible	Director of Nursing & AHP	Director of Nursing & AHP	16/11/23	Clinical Governance Committee	Monthly	-

Medium Risks

Ref No.	Category	Risk	Initial Risk Grading	Current Risk Grading	Target Risk Grading	Owner	Action officer	Next Scheduled Review	Governance Committee	Monitoring Frequency	Movement Since Last Report
Corporate CE 10	Reputation	Severe breakdown in appropriate corporate governance	Extreme x Possible	Extreme x Rare	Extreme x Rare	Chief Executive	Board Secretary	27/10/23	Corporate Governance Group	Quarterly	-
Corporate CE 11	Health & Safety	Risk of patient injury occurring which is categorised as either extreme injury or death	Extreme x Possible	Extreme x Rare	Extreme x Rare	Chief Executive	Head of Risk and Resilience	27/10/23	Clinical Governance Committee	Quarterly	-
Corporate CE 12	Strategic	Failure to utilise appropriate systems to learn from prior events internally and externally	Major x Possible	Moderate x Possible	Moderate x Unlikely	Chief Executive	Head of Risk and Resilience	27/10/23	Security, Risk and Resilience Oversight Group	Quarterly	-
Corporate CE 14	ALL	The risk that Coronavirus (Covid-19) could affect The State Hospitals primary aim to provide high quality, effective care and treatment and maintain a safe and secure environment for patients and staff.	Major x Almost Certain	Minor x Likely	Minor x Possible	Chief Executive	Senior Nurse for Infection Control/ Risk Manager	27/10/23	Corporate Governance Group	Quarterly	↓↑

Corporate CE15	Reputation	Impact of Covid-19 Inquiry	Extreme x Likely	Extreme x Rare	Extreme x Rare	Chief Executive	Board Secretary	27/10/23	Covid Inquiry SLWG	Monthly	-
Corporate MD 32	Medical	Absconsion of Patients	Major x Unlikely	Major x Rare	Moderate x Rare	Medical Director	Associate Medical Director	09/12/23	Clinical Governance Committee	Quarterly	-
Corporate MD 33	Medical	Potential adverse impact arising from clinical presentation out of hours with no doctor on site (5pm - 6pm)	Moderate x Unlikely	Moderate x Unlikely	Moderate x Unlikely	Medical Director	Associate Medical Director	09/12/23	Clinical Governance Committee	Quarterly	-
Corporate MD 34	Medical	Lack of out of hours on site medical cover	Major x Unlikely	Major x Unlikely	Major x Unlikely	Medical Director	Associate Medical Director	09/12/23	Clinical Governance Committee	Quarterly	-
Corporate SD 50	Service/Business Disruption	Serious Security Incident	Moderate x Possible	Major x Rare	Major x Rare	Security Director	Security Director	27/10/23	Security, Risk and Resilience Oversight Group	Quarterly	-
Corporate SD 51	Service/Business Disruption	Physical or electronic security failure	Extreme x Unlikely	Major x Unlikely	Major x Rare	Security Director	Security Director	27/10/23	Security, Risk and Resilience Oversight Group	Quarterly	-
Corporate SD 52	Service/Business Disruption	Resilience arrangements that are not fit for purpose	Major x Unlikely	Moderate x Unlikely	Moderate x Rare	Security Director	Security Director	27/10/23	Security, Risk and Resilience Oversight Group	Quarterly	-
Corporate SD 53	Service/Business Disruption	Serious security breaches (eg escape, intruder, serious contraband)	Extreme x Unlikely	Extreme x Rare	Extreme x Rare	Security Director	Security Director	27/10/23	Security, Risk and Resilience Oversight Group	Quarterly	-
Corporate SD 54	Service/Business Disruption	Implementing Sustainable Development in Response to the Global Climate Emergency	Major x Likely	Major x Unlikely	Moderate x Rare	Security Director	Head of Estates and Facilities	27/10/23	Security, Risk and Resilience Oversight Group	Quarterly	-
Corporate SD57	Health & Safety	Failure to complete actions from Cat 1/2 reviews within appropriate timescale	Moderate x Possible	Moderate x Possible	Moderate x Unlikely	Finance & Performance Director	Head of Corporate Planning and Business Support	27/10/23	Security, Risk and Resilience Oversight Group	Quarterly	-
Corporate ND 73	Service/Business Disruption	Lack of SRK trained staff	Moderate x Likely	Moderate x Possible	Moderate x Unlikely	Director of Nursing & AHP	Director of Nursing & AHP	27/10/23	Clinical Governance Committee	Quarterly	-

Corporate FD 90	Financial	Failure to implement a sustainable long term model	Moderate x Unlikely	Moderate x Unlikely	Moderate x Rare	Finance & Performance Director	Finance & Performance Director	06/11/23	Finance and Performance Group	Quarterly	-
Corporate FD 91	Service/Business Disruption	IT system failure	Moderate x Possible	Moderate x Possible	Moderate x Possible	Finance & Performance Director	Head of eHealth	06/11/23	Finance and Performance Group	Quarterly	-
Corporate FD 96	Service/Business Disruption	Cyber Security	Moderate x Unlikely	Moderate x Unlikely	Moderate x Rare	Finance and Performance Director	Head of eHealth	06/11/23	Information Governance Committee	Quarterly	-
Corporate FD 98	Reputation	Failure to comply with Data Protection Arrangements	Moderate x Unlikely	Moderate x Unlikely	Moderate x Rare	Finance and Performance Director	Head of eHealth/ Info Gov Officer	06/11/23	Information Governance Committee	Quarterly	-
Corporate FD 99	Reputation	Compliance with NIS Audit	Major x Likely	Moderate x Possible	Moderate x Rare	Finance and Performance Director	Head of eHealth	06/11/23	Information Governance Committee	Quarterly	-
Corporate HRD 110	Resource	Failure to implement and continue to develop the workforce plan	Moderate x Possible	Moderate x Unlikely	Minor x Rare	HR Director	HR Director	16/01/24	HR and Wellbeing Group	Quarterly	-
Corporate HRD 111	Reputation	Deliberate leaks of information	Major x Possible	Moderate x Possible	Moderate x Unlikely	HR Director	HR Director	16/01/24	HR and Wellbeing Group	Quarterly	-
Corporate HRD 113	Service/Business Interruption	Job Evaluation and impact on services in TSH	Major x Possible	Moderate x Possible	Negligible x Unlikely	HR Director	HR Director	16/01/24	HR and Wellbeing Group	Quarterly	NEW!

Low Risks

Ref No.	Category	Risk	Initial Risk Grading	Current Risk Grading	Target Risk Grading	Owner	Action officer	Next Scheduled Review	Governance Committee	Monitoring Frequency	Movement Since Last Report
Corporate CE 13	Strategic	Inadequate compliance with Chief Executive Letters and other statutory requirements	Moderate x Unlikely	Moderate x Rare	Moderate x Rare	Chief Executive	Board Secretary	27/01/24	Corporate Governance Group	6 monthly	-
Corporate SD 56	Service/Business Disruption	Water Management	Moderate x Unlikely	Moderate x Rare	Moderate x Rare	Security Director	Head of Estates and Facilities	27/01/24	Security, Risk and Resilience Oversight Group	6 monthly	-

Corporate FD 97	Reputation	Unmanaged smart telephones' access to The State Hospital information and systems.	Major x Likely	Moderate x Rare	Moderate x Rare	Finance and Performance Director	Head of eHealth	06/04/24	Information Governance Committee	6 Monthly	-
Corporate HRD 112	Health & Safety	Compliance with Mandatory PMVA Level 2 Training	Major x Possible	Moderate x Rare	Moderate x Rare	HR Director	Training & Professional Development Manager	16/01/24	Clinical Governance Group	6 Monthly	↓

Appendix 2

Risk to Operational Services – Job Evaluation

Ref: HRD113

Corporate Objective	Better Workforce	Risk Owner	HR Director	Action Officer	Head of HR

Risk	Complete the relevant details of the operation/ activity giving risk to the risk
The risk to operational services (through being unable to recruit or effect organisational change) where job descriptions cannot be evaluated, in accordance with the National Policy, in a reasonable time. Local target timeline is 14 weeks. Average timeline for outcomes given in 2023 is 15.25 weeks To demonstrate 'worst case' one post took 78 weeks and one took 48 weeks (both significant change to existing post holders). Appendix 1 outlines the timescales for all posts	

Category		Tick the box to indicate the type of risk Descriptions of categories and level of impact are available in TSH Risk Matrix
Patient Experience	☐	
Objectives/ Project	☒	
Injury (physical or psychological)	☐	
Complaints/ Claims	☐	
Service/ Business Interruption	☒	
Staffing and Competence	☐	
Financial (inc damage, loss or fraud)	☐	
Inspection/ Audit	☐	
Adverse Publicity/ Reputation	☐	
Physical Security	☐	
Other (Specify)		

Hazards	Details the hazards associated with this risk, i.e. the effect. Impact of this risk if realised
• Delays to recruitment could include roles which are funded on time limited, non-recurring funding. • There will be service implications where posts cannot be filled or change processes cannot be effected until the jobs are matched and band given. This will vary in significance dependant on the nature of the role/s. • Staff within teams and line managers will become disengaged demotivated by the delay • There may be risks to burnout / wellbeing of managers / colleagues particularly in small teams where a post remains unfilled.	

• Matching and Quality Checking is undertaken by trained practitioners who have substantive roles, there are no additional hours available for this. Means that commitment can be cancelled at short notice due to substantive priorities. Experienced practitioners are heavily relied upon to support those learning in panels and quality checking, fatigue and organisational scrutiny may impact motivation to contribute. • Poor quality JDs received, if progress to panel cannot be matched, waste valuable time and frustrate the practitioners. • Compliance with all terms of the policy requires different individuals to be available at different stages of the process for impartiality. • TSH has a total of 11 people who contribute to this process, this includes a smaller number of people trained in Quality Checking (x3). • Potential equal pay claims if the policy not complied with. • Training available led by the national team has been suspended. • The national network of other Board's which is relied upon to provide training opportunities on a 'shared service' is unreliable and as a small Board TSH has no trainers to offer, we must await training being held with spaces for our new practitioners to attend.		
Individuals or group exposed		Highlight those who would be affected by risk

Benefits	Detail any benefits associated with this risk being mitigated. (e.g. cost savings)
Being able to evaluate job descriptions as soon as possible enables managers to appoint to posts (whether through open recruitment or change processes) at the earliest opportunity. This ensures minimal disruption during staffing turnover and continuity of service. In the cases of significant change – any change to banding is effected as soon as possible and improves staff wellbeing.	

Existing Control Measures	List any existing measures in place to mitigate this risk.
▪ Managers are informed to keep JDs up to date on regular basis so these are available for recruitment ▪ Managers are advised to consider the National Job Sharing Protocol where appropriate and local process has been developed to effect this ▪ Managers should action recruitment activity as soon as employee resigns to minimise the timescale overall ▪ 'Time to hire' in TSH is positive minimising overall recruitment timeline.	

▪ Detailed analysis undertaken by JE Leads and Administrator monthly to ensure posts progress asap and barriers are addressed. ▪ Monthly JE Steering group taking place and well attended to encourage engagement in the process, hear feedback and address issues. ▪ Engagement of external staff side colleague to support almost 100% panels funded by HR department to ensure panels are populated by partnership. ▪ Communications have been developed to send to recruiting managers (and postholders in the case of significant changes) so they are aware of the stage of their role in the JE process, so they can be ready to act when confirmed and take into account other demands. ▪ Any change to banding is backdated to the date the JD was agreed so not detriment to employees terms and conditions, this is included on the submission paperwork. This is now included on the submission form. ▪ The quality and experience of the current practitioners varies however, all trained practitioners regularly contribute panels / quality checking which is monitored by the JE Leads. ▪ National network is attended by JE Leads and Administrator and have positive links with the National Leads for advice and support if possible. ▪ JE administration is undertaken by one post holder at present who is experienced in the process and has positive working relationship with local and national practitioners. ▪ Agreement from JE practitioners, at Steering Group for commitment to allow a minimum of 3 x JE panels to take place every month	

Likelihood	**Impact/Consequence**				
	Negligible	**Minor**	**Moderate**	**Major**	**Extreme**
Almost Certain	Medium	High	High	V High	V High
Likely	Medium	Medium	High	High	V High
Possible	Low	Medium	Medium	High	High
Unlikely	Low	Medium	Medium	Medium	High
Rare	Low	Low	Low	Medium	Medium

Risk Rating Refer to the QIS Matrix and descriptors (appendix 1) to assess the likelihood of the risk occurring and the impact it would have and determine the overall level of the risk.	**Impact/Consequence** (use descriptor relevant to proposal and select level of impact)	**Likelihood** (use descriptor relevant to proposal and select level of impact)	**Rating** R=I/C x L
Initial Risk Rating Risk grading without controls	Major	Possible	Medium
Target Movement Movement since last review	-	-	-
Target Risk Rating	Neglible	Unlikely	Low
Current Risk Rating	Moderate	Possible	Medium

Further Control Measures Required	Include any additional controls identified to eliminate or reduce the risk further.
Update the Job Evaluation submission form and associated acknowledgement email to confirm if the post is linked to time limited non-recurring funding, state this when submitting so the role can be prioritised accordingly as agreed by JE Leads which can be done quickly. Training material to be developed including guidance on writing good job descriptions and options available for managers when recruiting. Due for consideration at October JE Steering Group Pro-active escalation from JE admin to HR Advisor to support the manager / team, including consideration of: o the risks associated with recruiting 'subject to' receiving a banding which are dependent on the circumstances. o Consideration of short term placements through the "alternative duties guidance" - ASAP More detailed analysis on receipt of updated / changed JDs to ensure that only those which are significant and require matching progress – for consideration at October Steering Group Consideration of linking with other Board/s to provide expertise in areas we lack trained practitioners, and we could release a panellist for example – as and when required Development of the monthly reporting mechanism to better reflect progress against the 14 week timescale – by October 2023 Create a succession plan for job evaluation practitioners to ensure sustainability, particularly for specialist areas like quality checking. Utilisation of the national job sharing protocol on every appropriate opportunity.	

Assurances and KPIs	What assurances are there that current controls are effective? (Internal and external) Detail any existing KPIs that would link to risk and show performance against risk
Progress and status is now reported monthly in the workforce paper which is presented at Workforce Governance, OMT, CMT, HR & Wellbeing, Partnership Forum & quarterly to Staff Governance. 6 monthly report on status will be completed to Workforce Governance and CMT (due January 2024). Local timeline indicates 14 week from receipt to outcome given.	

Date Added	29/09/2023
Completed by	Laura Nisbet, Head of HR
Date Reviewed	29/09/2023
Next Review	29/12/2023

Risk Register	Corporate Risk Register
Directorate	Human Resources and Workforce
Group/Committee Monitoring Risk	HR and Wellbeing Group

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	26 October 2023
Agenda Reference:	Item: 8
Sponsoring Director:	Director of Nursing, AHPs and Operations
Author(s):	Senior Nurse for Infection Control
Title of Report:	Infection Prevention & Control Report
Purpose of Report:	For Noting

1. SITUATION

This is the update paper on Infection Prevention and Control activity for the period 1st August – 30th September.

2. BACKGROUND

The NHS Scotland HAI Action Plan 2008 requires an HAI report (HAIRT) to be presented to the Board on a two monthly basis. The State Hospital does not routinely screen for organisms specified. This report provides an overview of general infection prevention and control activity, together with results from cleanliness monitoring and hand hygiene audit results.

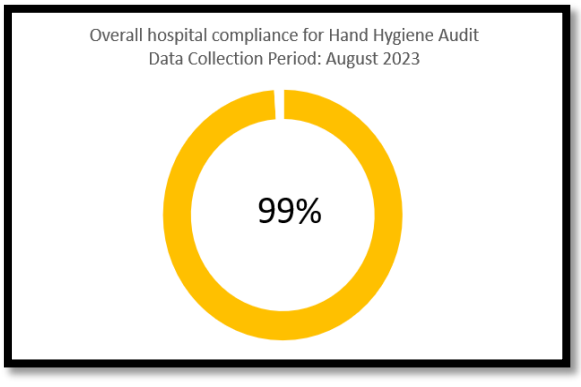
3. ASSESSMENT

I. Infection Prevention & Control Activity

The Infection Prevention and Control Group have met on three occasions and the Infection Control Committee on one occasion. There have been no areas of concern that require further escalation.

II. Hand Hygiene

<u>August</u>

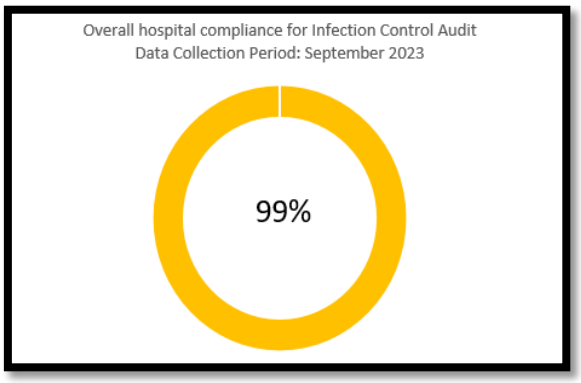


Hand Hygiene August Summary:

- The overall percentage has decreased by 1%. Taking overall complience back into amber on the RAG scale
- 100% (16 clinical areas) returned the completed audit tool
- 99% (15 clinical areas) reported a compliance of 100%
    - Arran 1 - observed a member of porters staff not adhering to one of the 5 key moment

(After contact with patients surroundings) – CQIF has contacted Head of Estates to ask that all portering staff are aware of the importance of complying with the 5 key moments and if they require any Infection Control support.

<u>September</u>



Hand Hygiene September Summary

The overall percentage of compliance remains at 99%, no change since June 23

- 100% (16 clinical areas) returned the completed audit tool
- 99% (14 clinical areas) observed a 100% compliance
- 1% (2 clinical areas) non compliance were:
    - Arran 1– member of staff in clinical area wearing a watch. Charge Nurse on shift reminded member of staff of the uniform policy and watch was removed
    - Mull1 – member of staff in clinical area wearing a watch. Charge Nurse on shift reminded member of staff of the uniform policy and watch was removed

This will continue to be monitored by the CQIF in relation to the actions taken and areas of concerns will be raised at the Infection Control Group and OBG.

III. Cleanliness and Facilities Monitoring

Domestic

<u>August</u>

From 1st August – 31st August the overall compliance with the National Cleaning Specification was 96.42% (green) a slight increase on July (93.41% green). All areas monitored were within the 'green range'. The areas which have require improvement have predominately been within 2 wards

Targeted areas for monitoring include, refuse, appliances/fixtures/fittings, furniture/fittings, soap/hand towels, floors and low level cleaning. This is a similar theme to last report; however it was different areas being audited. The infection control team will be involved in the induction program for housekeeping staff and will undertake targeted training in these areas. The infection control team will continue to monitor and provide

<u>September</u>

From 1st September – 30th September the overall compliance with the National Cleaning Specification was 95.11% (green) as slight decrease from previous mornth 96.42%.

Estates

From 1st September – 30th September the overall compliance was 99.71 (green), comparative with last report. The recurring theme for rectifications is "skirting-damaged surface/stained dim strip loose" and "walls damaged/dampness wall scratched". These are the same issues reported in August albeit from different areas. This will be managed by the Estates team.

IV. COVID19 Activity

The number of patients that have tested positive for Covid19 during this review period is 9 (1st August – 30th September 2023). Total number of positive Covid cases from March 2020 is 169.

Lewis 2 = 5 patients
Arran 1 = 2 patients
Arran 3 = 2 patients

Standard Operating Procedure for the Management of a Suspected/Confirmed Case of a Respiratory Illness has been updated and approved by the Infection Control Committee (14.09.2023). the new SOP was implement for the outbreak in Arran 1 & Arran 3, with no adverse effects noted.

National Guidance

SGHD/CMO (2023)12 - Advance notice of changes to Scottish Government's COVID19 testing guidance. Following a clinical review, the Cabinet Secretary for NHS Recovery, Health and Social Care, the Cabinet Secretary for Justice and Home Affairs, and the Minister for Social Care, Mental Wellbeing and Sport have agreed to pause all Scottish Government COVID-19 routine testing guidance in health, social care and prison settings. An exception to this pause is for individuals in hospital, prior to being discharged to a care home or a hospice: this routine testing will remain.

Testing protocol for COVID-19 will revert to testing as appropriate to support clinical diagnosis and for outbreak management as per the National Infection Prevention and Control Manual, or on advice from local Infection Prevention and Control Teams or local Health Protection Teams.

Following this publication the Standard Operating Procedure for the Management of a Suspected/Confirmed Case of a Respiratory Illness has been updated and approved by the Infection Control Committee (14.09.2023). The key change to the SOP is the removal of the need for 2 consecutive negative LFD tests before returning to normal activities and the testing of asymptomatic ward contacts.

4. RECOMMENDATION

The Board is invited to

1. Note the content of this report.

MONITORING FORM

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

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	26 October 2023
Agenda Reference:	Item No: 9
Sponsoring Director:	Medical Director
Author(s):	PA to Medical Director
Title of Report:	Bed Capacity within The State Hospital and Forensic Network
Purpose of Report	For Noting

1 SITUATION

Capacity within the State Hospital (TSH) and across the Forensic Network has been problematic and requires monitoring.

2 BACKGROUND

a) TSH

The following table outlines the high level position from the 1 August 2023 until 30 September 2023.

Table 1

	Admissions & Acute	Treatment & Recovery	Transitions	ID	Total
Bed complement	24	48	24	24 (includes 12 surge beds)	120 (+ 20 additional unstaffed beds)
Beds in use	20	48	21	12 + 3 surge	104
Admissions	3 (external) 0 (internal)	0 (external) 4 (internal)	0 (external) 4 (internal)	0 (external) 0 (internal)	3 (external) 8 (internal)
Discharges/Transfers	1(external) 3 (internal)	1 (external) 3 (internal)	0 (external) 1 (internal)	0 (external) 0 (internal)	2 (external) 7 (internal)
Bed occupancy as at 30/09/2023	83.3%	100%	87.5%	62.5% (all beds)	86.7% (available beds)

				125% (ID beds)	74.3% (all beds)

Please note that in total there were 104 patients as of 30 September 2023, within this number 15 patients are under the care of the Intellectual Disability Service (the service is currently 3 patients in excess of their 12 patient allocation).

18 patients have been identified for transfer from TSH and 7 have been fully accepted for transfer. Of these 7, 2 have been waiting for over a year, this is due to availability of beds and discussions are ongoing between RMO's and local services to resolve this. Three patients have won excess security appeals and one of these has won a second appeal. Full details are available but not included for reasons of patient confidentiality.

There are no patients at TSH under the Exceptional Circumstances clause.

b) TSH Contingency Plan

Following the new Clinical Model being implemented, a SOP for surge bed contingency planning has been agreed through the Clinical Model Oversight Group. Currently 1 patient has been identified through this process to assist with a bed being available in the event of there being no Male Mental Illness beds being available.

c) Forensic Network Capacity

The Board received copies of the Forensic Network's short-, medium- and long-term plans to improve capacity across the forensic estate. These were requested by Scottish Government. We receive a weekly forensic estate update report from the Forensic Network to aid patient flow. The Orchard Clinic has temporarily reduced its capacity by 7 beds for urgent repairs.

3 ASSESSMENT

The current bed situation within TSH is tight because of the new clinical model but manageable. We continue to have surge beds available should we need to move to our bed contingency plan. It is recognised that there is a natural variation in the number of referrals and admissions and we are impacted by capacity in lower levels of security.

The Orchard Clinic's temporary closure of 7 beds for urgent work is causing further pressure across the forensic estate.

4 RECOMMENDATION

The Board is asked to note the report.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	The report supports strategy within the hospital, and all associated assurance reporting.
Workforce Implications	N / A
Financial Implications	N / A
Route To Board Which groups were involved in contributing to the paper and recommendations	Board requested as part of workplan
Risk Assessment (Outline any significant risks and associated mitigation)	The various reports throughout the year would include any issues
Assessment of Impact on Stakeholder Experience	All the reports are assessed as appropriate
Equality Impact Assessment	All the reports are assessed as appropriate
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do)	All the reports are assessed as appropriate
Data Protection Impact Assessment (DPIA) See IG 16	Tick One √ There are no privacy implications. □ There are privacy implications, but full DPIA not needed □ There are privacy implications, full DPIA included

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	26 October 2023
Agenda Reference:	Item No: 10
Sponsoring Director:	Director of Nursing and Operations
Author(s):	Professional Nurse Advisor
Title of Report:	Clinical Model Oversight Group – Update Report
Purpose of Report:	Update

1 SITUATION

This report provides the Board with an update on the work of the Clinical Model Oversight Group (CMOG) since its inception in May 2023.

2 BACKGROUND

The CMOG was established in May 2023 to provide an overarching forum for collaborative leadership working across the hospital under the new clinical services structure. The meeting is co-chaired by the Associate Medical Director and the Professional Nurse Advisor, and attended by key personnel for each of the clinical service areas. Meetings occur on a monthly basis.

2 ASSESSMENT

Over recent months the key focus of the CMOG group has been to establish itself as a collective leadership forum, to support each of the service leadership teams to grow in their new functions and structures, and to respond to any emerging issues following changes to the clinical model structure.

As part of the standing agenda each service provides a progress update from their speciality areas. In addition to sharing learning and good practice the forum also acts as a collaborative space to explore any areas of emerging concern, both from a clinical and operational perspective.

Key issues discussed by the group over recent meetings have included:

- Patient flow through each of the services
- The requirement for a centralised referral process for movement of patients between clinical services, and the most appropriate forum for the discussion of those patient referrals is under review and will be discussed with the Patient Pathway Group and CMOG.
- Ongoing concerns about the impact of Daytime Confinement (DTC) across each of the services and potential disparity of ward closures across each of the services.
- The ongoing work to create a more accurate reporting system within RiO for the monitoring of daytime confinement. The Head of Risk and Resilience has been invited to the next

CMOG to provide a demonstration of the recording platform and capabilities, and discuss how each of the services can use this data for improvement going forward.

- Ongoing concerns about the current increase in clinical demand/requirement for patients to leave the site for physical health investigations and treatment and the impact this is having on patients (i.e. Daytime Confinement). It is recognised that such changes are part of natural variation and not the cause of DTC.

As earlier identified the primary focus of the CMOG forum over recent months has been to support each of the service areas to develop and grow as new teams. Going forward the forum will also review and report on specific Key Performance Indicator (KPI) data. A meeting has been arranged for 24 October 2023, between the co-chairs of CMOG and the Head of Clinical Quality, to discuss KPIs in more detail. Thereafter, these will feature as part of the CMOG reporting process to the Clinical Governance Group.

4 RECOMMENDATION

The Board are invited to note the content of this update report.

MONITORING FORM

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

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	26 October 2023
Agenda Reference:	Item No: 11
Sponsoring Director:	Medical Director
Author(s):	PA to Medical & Associate Medical Directors
Title of Report:	Medical Appraisal and Revalidation 1 April 2022 – 31 March 2023
Purpose of Report:	For Noting

1 SITUATION

It is a requirement of NHS Education for Scotland that an annual report on Medical Appraisal and Revalidation is placed before the Board.

2 BACKGROUND

Revalidation is the process by which doctors demonstrate to the General Medical Council (GMC) that they are up to date and fit to practise, and comply with the relevant professional standards. The information doctors provide for revalidation is drawn by doctors from their actual practice, from feedback from patients and colleagues, and from participation in continued professional development (CPD). This information feeds into doctors' annual appraisals. The outputs of appraisal lead to a single recommendation to the GMC from the Responsible Officer in their healthcare organisation, normally every five years, about the doctor's suitability for revalidation.

Within the State Hospital, an agreed data set for annual appraisals is collated centrally by the Appraisal and Revalidation Administrator (this is the PA to the Medical & Associate Medical Director). This includes Clinical Effectiveness Data, Pharmacy Audits, CPA / Restricted Patient and Medical Record Keeping Audits.

3 ASSESSMENT

- The Revalidation and Appraisal Committee met twice in 2022-23: 2 May 2022 and 7 November 2022. .

- Revalidation Policy
  The Revalidation and Appraisal Policy was approved by the Senior Management Team on 3 August 2016 and is available on the Intranet under HR Connect. The Policy will be reviewed at the next Revalidation and Appraisal meeting on 7 November 2023.

- Responsible Officer
  Professor Thomson has undertaken Responsible Officer training and attends Responsible Officer Network meetings.

- Revalidation System
  Revalidation system has been used for 10 Consultants and 2 speciality doctors in 2022-23. This includes one doctor on secondment to Scottish Government. One Consultant is appraised and revalidated through the Chief Medical Officer system.

- Appraisals
  From 1 April 2022 to 31 March 2023, of the 12 medical staff within The State Hospital revalidation system, 12 were appraised during this period. 2 new Consultants have been appointed and will be included in future reports.

- Revalidation
  All revalidations are up to date.

- Multi-source feedback
  Multi-source feedback using the SOAR system is now being submitted by medical staff at appraisal meetings. This is required once per 5 year cycle.

- CARE Questionnaire
  The CARE questionnaire was issued to patients in November 2022 for all Consultants. Questionnaires for Specialty Doctors and Consultant Psychotherapist will be issued in early 2024.

- SOAR Appointment System
  SOAR appointment system was ntroduced to avoid delays in annual appraisals. A doctor will be invited to an appraisal appointment at mutually agreed times on three occasions. Standard letter to doctors not engaging in the process in terms of attending an appointment or submitting paperwork has been prepared. This has never been used to date.

- Case based discussions are included in the appraisal process. There is a monthly allocated slot open to Trainees, Specialty Doctors or Consultants where cases can be discussed by the medical staff group.

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Consultants	Last Date for Recommending Revalidation	Date of Revalidation	CARE Questionnaire Return	Form 4 Completed	Appraisal 01/04/19-31/03/20	Appraisal 01/04/20-31/03/21	Appraisal 01/04/21-31/03/22	Appraisal 01/04/22 – 31/03/23	Appraisal 01/04/23 – 31/03/24	AMP Training		Last date to register for refresher training	Refresher training
										Forensic	Core & Capacity		
	20/11/2023	31/10/2018	Nov 2022	Yes	28/08/2020	20/07/2021	10/03/2022	15/03/23		01/02/19	29/05/21	**Jan 24**	17/11/23
	15/10/2026	16/10/2021	Nov 2022	Yes	24/09/2019	01/10/2020	26/10/2021	31/10/22		31/08/22	21/06/18	July 24	17/01/23
	01/09/2026	02/09/2021	Nov 2022	Yes	04/02/2020	31/08/2020	01/06/2021	25/10/22		01/02/19	29/05/21	**Jan 24**	
	12/02/2025	04/04/20	Nov 2022	Yes	28/01/2020	01/06/2021	16/03/2022	17/01/23		25/11/19	21/06/18	Oct 24	11/10/22
	01/08/2026	31/05/2021	Nov 2022	Yes	15/03/2019	30/03/2021	26/01/2022	23/01/23		01/02/19	31/10/19	Jan 24	17/11/23
	26/12/2027	02/05/2022	Nov 2022	Yes	05/11/2019	27/11/2020	04/10/2021	28/11/22	16/11/23	20/09/21	29/05/21	Aug 26	
	28/03/2024	11/03/2019	Nov 2022	Yes	28/02/2019	02/02/2021	08/03/2022	06/02.23	02/11/23	01/02/19	29/05/21	**Jan 24**	
	20/12/2026	24/05/2021	Nov 2022	Yes	12/12/2019	23/11/2020	25/10/2021	29/09/22	12/10/23	01/02/19	29/05/21	Jan 24	17/11/23
	28/07/2026	31/05/2021	Nov 2022	Yes	20/01/2020	16/02/21	11/02/22	30/01/23			29/05/21	April 26	
	20/03/2025	11/12/2019	Nov 2022	Yes		05/10/2020	12/11/2021	10/02/23		05/01/23	09/12/19		05/01/23
	17/08/28									22/07/20		July 25	
										30/10/18			17/11/23
Specialty Doctors													
	02/02/2027	24/01/2022					05/10/2021 19/10/2021	18/10/22		6-8/7/21		June 26	
	13/10/2024							06/09/22		Not eligible until 2023			
Appraised by Other Organisations													
	15/12/2023	15/12/2018	Nov 2022	Yes	30/04/2019	15/10/2020	12/10/2021	23/11/22			29/05/21	April 26	
Retired Consultants													

4 RECOMMENDATION

The Board is invited to note the content of the Medical Director's Report.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	N/A
Workforce Implications	Revalidation and appraisal are requirements to work as a doctor and essential to ensuring our continued medical workforce.
Financial Implications	Nil
Route To Board Which groups were involved in contributing to the paper and recommendations.	HIS requirement. Report will be shared with MAC.
Risk Assessment (Outline any significant risks and associated mitigation)	No significant risks identified
Assessment of Impact on Stakeholder Experience	Captures feedback on stakeholder experience and provides opportunity to improve this
Equality Impact Assessment	EQIA Screened – no identified implications
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	N/A
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One X There are no privacy implications. □ There are privacy implications, but full DPIA not needed □ There are privacy implications , full DPIA included.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Board Meeting:	26 October 2023
Agenda Reference:	Item No: 12
Authors:	Dr Callum A MacCall, Dr Natasha Billcliff
Sponsoring Director:	Prof. Lindsay Thomson, Medical Director
Title of Report:	Annual Medical Education Report

1 SITUATION

The General Medical Council (GMC) Quality Improvement Framework for Undergraduate and Postgraduate Medical Education in the UK sets out expectations for the governance of medical education and training. GMC standards specifically refer to Board governance and it is within this context that this report is being presented to the Board. This report covers the period 1st August 2022 to 31st July 2023.

2 BACKGROUND

Dr Callum A MacCall is Educational Supervisor at The State Hospital (TSH). He is responsible for postgraduate medical training while Dr Natasha Billcliff & Dr Sheila Howitt lead on issues relating to medical undergraduates. The Educational Supervisor reports within the State Hospital to Professor Lindsay Thomson, Medical Director. He reports externally to the Training Programme Director for Forensic Psychiatry Higher Training in Scotland, Dr Partha Gangopadhyay, and to local Training Programme Directors for Core Training.

3 ASSESSMENT

3.1 UNDERGRADUATE TRAINING

Teaching Program Placements for Undergraduate Medical Students 2022/23

We continue to offer Edinburgh University students the opportunity of a two-week placement, which can be arranged via their clinical tutors on an ad hoc basis. This is discussed with students on the first day of their attachments. Given that this route was previously not leading to students accessing TSH, Dr Thomas (who coordinates the undergraduate teaching at Edinburgh University) advertised the placement with tutors, leading to NHS Borders taking up our offer. This meant that for the last academic year, two students from the Borders per block have been on placement at TSH for a week.

For the next academic year, we will also be taking regular Edinburgh University students on placement in Liaison psychiatry. The details of this are currently being discussed.

Student numbers in the last academic year are as follows:

Edinburgh University	20 students for one week placement, 16 students on day placements
Glasgow University	1 student for 2 weeks, one for a week and one for a day placement
Dundee University	1 student for 2 weeks, 2 students for a 1 day placement

There is no formal feedback gathered by the universities for TSH placements presently.

Forensic Tutorials

The 6 weekly forensic online tutorials were cancelled last year. I have been in correspondence with Dr Thomas and for the next academic year TSH with again deliver tutorials, remotely, for each of the 6 blocks of students. We will be incorporating key themes that came up with the curriculum review including the Mental Health Act and capacity, recognising the individual and social impacts of mental illness, and the wider stigma and attitudes towards mental health. If the day visit to TSH can be recommenced then the forensic lecture can once more be delivered in person. Dr Thomas has confirmed the funding for the day visit and is in the process of organising same.

Tutors Meeting

The Tutors and Clinical Teachers meeting for undergraduate students at Edinburgh University was not held this year. Dr Thomas noted that he is in the process of developing new learning outcomes from the General Medical Council and Royal College of Psychiatrists guidance for the undergraduate curriculum and will be recruiting new

tutors for the next academic year. We have let him know views from TSH that the tutors meeting would be useful, especially for services not based in Edinburgh, to keep up to date with changes to teaching.

3.2 POST GRADUATE TRAINING

Core Training

Over the past year, we have had six Core Trainees (CTs) on placement at TSH, four from the West of Scotland and two from the East. In common with the growing tendency in recent years, two of these Doctors were less than full time (LTFT), both with an 80% working pattern.

First On-Call Rota

In the initial part of the past year there were gaps in our first on-call rota arising from LTFT working and a Specialty Doctor vacancy. These were filled on a locum basis, with the other doctors sharing the available locum slots between them. The picture has been much improved since early 2023 when we appointed a third Specialty Doctor, thus bringing the number of Core Trainees and Specialty Doctors on our first on-call rota up to six. This rota is now more secure than it has been in recent years, when we have frequently had at least one doctor missing from our 1:6 overnight on-call rota.

Higher Specialty Trainees

Over the past year we have had five Specialty Trainees (STs) placed with us, for periods of varying length, generally being either three or six months. One of these trainees worked 60% LTFT.

Our Specialty Trainees work under the supervision of Consultant Trainers. We are well positioned with regard to our availability of experienced trainers across a variety of specialties, as outlined in Appendix 1.

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

Senior Speciality Trainees in their final year of training (ST6) can act up as a Consultant for a maximum period of 12 weeks. This has not occurred during the period relating to this report.

Performance on Scottish and GMC National Training Surveys

I am delighted to be able to report I have been contacted by Alex McCulloch, Senior Quality Improvement Manager at NHS Education for Scotland to advise that TSH is now within the top 2% of training sites in Forensic Psychiatry. Feedback from trainee doctors who completed both the Scottish Training Survey and the GMC National Training Survey over the past year was extremely positive across the board. A summary of the survey feedback and commentary from Alex McCulloch is included in Appendix 2.

Scotland Deanery Quality Management visit report

On 26th April 2023, we had an NHS Education for Scotland (NES) visit led by Associate Postgraduate Dean for Quality Dr Claire Langridge. The outcome of this visit was very positive. The NES team noted the provision of excellent educational resources on site, a cohesive staff group, an engaging Quality Improvement team and a high quality & amount of local teaching for trainee doctors. There were no immediate actions or any requirement for follow-up from NES after the visit. Areas for improvement have been acted upon. The full report of the visit is attached in Appendix 3.

Teaching Programme

A series of six lectures is delivered by Consultant Psychiatrists to Trainee Doctors during the first three months of their placement at the State Hospital. The current programme encompasses six lecture topics, which broadly cover the fundamentals of Forensic Psychiatry and related practice. A system allowing Trainees to deliver feedback on the quality of the lectures delivered has been developed. Trainees are asked to rate the teaching according their agreement with statements on how engaging the lecture was, how well the content met expectations, the helpfulness of the knowledge & skills taught, the relevance of the presentation materials and the overall quality of the presentation. Over the past year nine evaluation forms were returned. 100% of received feedback for the lectures was positive, being in either the ‘agree’ or ‘strongly agree’ categories for all items rated.

Monthly Educational Programme

A monthly Educational Forum delivered using a webinar format has continued over the past year, organised by Dr Jana De Villiers. This gives trainee psychiatrists the opportunity to present cases, papers and audit/research, as well as to be educated by other internal and external speakers. This is important for their training and portfolio development and is well received.

New to Forensic Programme

A joint venture between NHS Education for Scotland (NES) and the School of Forensic Mental Health (SoFMH) the 'New to Forensic (N2F)' education programme is designed to meet the needs of clinical and non-clinical staff, both new and already working within forensic mental health services. The programme is designed to promote self-directed learning and is multi-disciplinary and multi-agency in approach. The mentee is supported throughout their period of study (recommended six months to one year, depending on previous experience) by a mentor who is an experienced mental health worker. The programme has 15 chapters, which all but one include case scenarios of patients in various settings, from high secure to community psychiatric care.

Over the past year all trainee Psychiatrists arriving on placement at TSH who have not previously done the programme (in some cases doctors have already previously completed the programme elsewhere or on previous placements at TSH and/or are already very experienced in working within forensic settings) have been registered with N2F and provided with the materials to allow them to complete the programme with their Consultant clinical supervisors. TSH Medical Secretary Claire McCrae, who provides administrative support to Dr MacCall, helpfully liaises with staff at the Forensic Network at the point of commencement and it is then the responsibility of the mentee and mentor to ensure the programme is completed. Three trainees have so far been formally signed off as having completed the programme with the Forensic Network over the past year, while the others are currently in the process of concluding same.

State Hospital Visits

Occasional requests for "taster visits" by Foundation Grade Doctors / Core Trainees / non-forensic Specialty Trainees are received on an intermittent basis. These Doctors are curious to find out more about Forensic Psychiatry and, in some cases, they have an interest in pursuing Forensic Psychiatry as a career. During the past year, we had one visit, which took the form of a clinical attachment over a period of four weeks. Clinical attachments are a useful way for international medical graduates to get a taste of the working lives of doctors in the NHS. Our visiting doctor observed the practice of one of our Consultant Forensic Psychiatrists without having any responsibilities for patient care.

Psychotherapy Training

We have part-time input from a Consultant in Forensic Psychotherapy, Dr Adam Polnay. He provides Balint & Reflective Practice sessions for non-Consultant grade Doctors. He also supports Core and Specialty Trainees identify opportunities for involvement in individual or group psychotherapy activities. Such work forms part of their core psychotherapy training requirements and have continued to be valued by training grade doctors on placement at The State Hospital.

Recruitment & Trends in Working Patterns

Less than full time (LTFT) working patterns have remained popular with trainee psychiatrists over the past year. Recruitment has been strong and there has been a high fill rate in Core and Specialty Trainee posts in Scotland over the past year. This trend, which appeared during the Covid-19 pandemic, appears to be continuing. With the higher availability of training grade doctors on the rotations which send us doctors on placement, and the successful recruitment of a third non-training grade Specialty Doctor at The State Hospital, we are now on a more positive footing with regard to our non-consultant grade medical workforce than we have been in a number of years.

Representation at External Committees Relevant to Medical Education

Over the past year, Dr MacCall has represented The State Hospital at the following:

- West of Scotland Specialty Training Committee (STC)
- National Forensic Psychiatry Specialty Training Committee (STC)
- Bi-annual NHS Education for Scotland Annual Review of Competence Progression (ARCPs)

4 RECOMMENDATION

The Board is invited to note what has been a very positive year for The State Hospital with regard to medical education. We have continued to provide extensive high quality undergraduate and postgraduate medical training via a well-trained and experienced Consultant workforce. Particular strengths have included a further very positive NES Deanery visit in April 2023 and ending the year with extremely positive feedback from training surveys, placing us within the top 2% of training sites within forensic psychiatry nationally. Our recruitment and fill rate is strong and we are able to enter the forthcoming year on a positive footing.

Dr Callum A MacCall

Dr Callum A MacCall
Consultant Forensic Psychiatrist & Educational Supervisor
Honorary Senior Clinical Lecturer, University of Glasgow

5th August 2023

Date of next annual report – August 2024

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	This is an annual report to the Board on issues relevant to medical education at The State Hospital.
Workforce Implications	Nil
Financial Implications	Nil
Route to Board Which groups were involved in contributing to the paper and recommendations?	Prepared by individuals and informed by their involvement in various medical education committees.
Risk Assessment (Outline any significant risks and associated mitigation)	N/A
Assessment of Impact on Stakeholder Experience	Nil
Equality Impact Assessment	N/A
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do)	There are no identified impacts.

Data Protection Impact Assessment (DPIA) See IG 16.	Tick One ✓ There are no privacy implications. □ There are privacy implications, but full DPIA not needed □ There are privacy implications, full DPIA included.

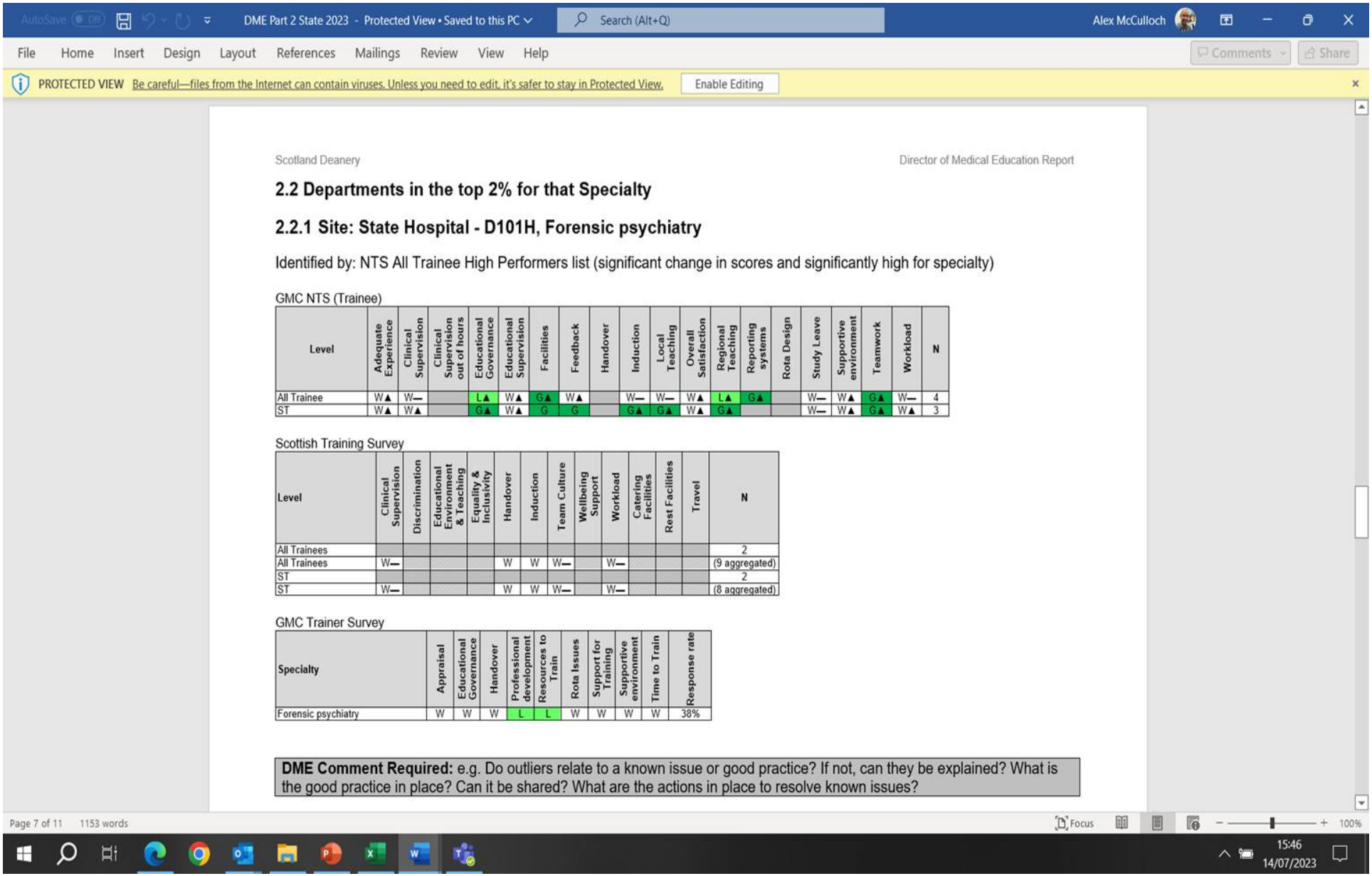
APPENDIX 1 – Recognition of Trainers

Consultant Psychiatrist	NES Clinical Supervisor Course or equivalent	NES Educational Supervisor Course or equivalent	Named Medical Trainer Role	Forensic, Intellectual Disabilities+ or Psychotherapy++ Higher Specialty Trainer	Recognised Trainer via Recognition of Trainers (RoT) section of Scottish Online Appraisal Resource (SOAR)
Consultant Forensic Psychiatrist	Yes				Yes
Consultant Forensic Psychiatrist	Yes				Yes
Consultant Forensic Psychiatrist	Yes		Undergraduate Supervisor	Yes	Yes
Consultant ID Psychiatrist	CEP* Level 2			Yes+	Yes
Consultant Forensic Psychiatrist	CEP* Level 2		Undergraduate Supervisor		Yes
Consultant Forensic Psychiatrist	Yes	Yes		Yes	Yes
Educational Supervisor	Yes	Yes	Postgraduate Supervisor	Yes	Yes
Consultant Forensic Psychiatrist	CEP* Level 2			Yes++	Yes
Consultant Psychiatrist in Psychotherapy	CEP* Level 3		Psychotherapy Tutor (Lothian)	Yes++	Yes
Consultant Forensic Psychiatrist	Yes			Yes	Yes
Medical Director	Fellow HEA**	Yes		Yes	Yes

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

Appendix 2

TSH is very much in the top 2% in the NTS High Performers list for both change in scores and significantly high scores for that specialty. Very positive data.



2.2 Departments in the top 2% for that Specialty

2.2.1 Site: State Hospital - D101H, Forensic psychiatry

Identified by: NTS All Trainee High Performers list (significant change in scores and significantly high for specialty)

GMC NTS (Trainee)

Level	Adequate Experience	Clinical Supervision	Clinical Supervision out of hours	Educational Governance	Educational Supervision	Facilities	Feedback	Handover	Induction	Local Teaching	Overall Satisfaction	Regional Teaching	Reporting systems	Rota Design	Study Leave	Supportive environment	Teamwork	Workload	N
All Trainee	W▲	W—		L▲	W▲	G▲	W▲		W—	W—	W▲	L▲	G▲		W—	W▲	G▲	W—	4
ST	W▲	W▲		G▲	W▲	G	G		G▲	G▲	W▲	G▲			W—	W▲	G▲	W▲	3

Scottish Training Survey

Level	Clinical Supervision	Discrimination	Educational Environment & Teaching	Equality & Inclusivity	Handover	Induction	Team Culture	Wellbeing Support	Workload	Catering Facilities	Rest Facilities	Travel	N
All Trainees													2
All Trainees	W—				W	W	W—		W—				(9 aggregated)
ST													2
ST	W—				W	W	W—		W—				(8 aggregated)

GMC Trainer Survey

Specialty	Appraisal	Educational Governance	Handover	Professional development	Resources to Train	Rota Issues	Support for Training	Supportive environment	Time to Train	Response rate
Forensic psychiatry	W	W	W	L	L	W	W	W	W	38%

DME Comment Required: e.g. Do outliers relate to a known issue or good practice? If not, can they be explained? What is the good practice in place? Can it be shared? What are the actions in place to resolve known issues?

Alex McCulloch
Senior Quality Improvement Manager
NHS Education for Scotland
alex.mcculloch@nhs.scot

Please note I am currently working from home and will be available via email

Key to survey results

Scottish Training Survey (STS)

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

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

GMC National Training Survey (NTS)

Key	
R	Result is below the national mean and in the bottom quartile nationally
G	Result is above the national mean and in the top quartile nationally

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

No Aggregated data is available this year

- The information used to create the STS Triage lists is from Scotland only. The NTS triage lists are based on UK data.
- If criteria is met from any of the following lists (bottom 2%), they will be noted on the triage list; NTS All Trainee list, NTS Level of trainee list, STS All Trainee List, STS Level of trainee List and NTS Trainer Survey Data List. The criteria used for the triage list are: Number of red flags, significant change in scores, significantly low scores for Specialty, excess triple red flags, aggregated low scores for Specialty and number of aggregated red flags (if applicable).
- If criteria is met from any of the following lists, they will be noted on the High Performers list (top 2%); NTS All Trainee list, NTS Level of trainee list, STS All Trainee list, STS Level of trainee list and NTS Trainer survey data list. The Criterion for the High Performers list are: Triple green flags, significant change in scores, number of green flags, persistent high score, high scores for specialty
- A site can be on both the High Performers and Triage lists because of different scores for the different criterion being in the top or bottom 2%. Two departments with similar results can have different outcomes because of the 2% threshold, as they may be just either side of the threshold meaning one is on the main part of the DME report.
- Please note the number of trainees may not always tally due to the inclusion of programme trainees within the data. For example, Dermatology trainees in a post may actually be part of the Medicine Programme.

Appendix 3

Scotland Deanery Quality Management Visit Report

NHS Education for Scotland

Date of visit	26th April 2023	**Level(s)**	CT & ST
Type of visit	Triggered	**Hospital**	State Hospital
Specialty(s)	Forensic Psychiatry	**Board**	National Facility

Visit panel	
Dr Claire Langridge	Visit Chair - Associate Postgraduate Dean – Quality
Dr Daniel Bennett	Associate Postgraduate Dean
Dr Manjit Cartlidge	Trainee Associate
Mr Bill Rogerson	Lay Representative
Mrs Natalie Bain	Quality Improvement Manager
In attendance	
Mrs Susan Muir	Quality Improvement Administrator

Specialty Group Information		
Specialty Group	Mental Health	
Lead Dean/Director	Professor Clare McKenzie	
Quality Lead(s)	Dr Alastair Campbell & Dr Claire Langridge	
Quality Improvement Manager(s)	Mrs Natalie Bain	
Unit/Site Information		
Non-medical staff in attendance		
Trainers in attendance	8	
Trainees in attendance	1xST, 3xCT	

Feedback session: Managers in attendance	Chief Executive	x	DME	x	ADME	x	Medical Director	x	Other	

Date report approved by Lead Visitor	15th May 2023

1. Principal issues arising from pre-visit review:

The Mental Health Quality team at Scotland Deanery triggered a visit in view of survey data relating to Forensic Psychiatry at The State Hospital, National Facility. The visit team planned to investigate the red flag at ST level in the 2022 National Training Survey for clinical supervision out of hours (see section 2.21), as well as pink flags in relation to adequate experience, clinical supervision, educational governance, educational supervision, induction, overall satisfaction, rota design, supportive environment and workload. The visit team also used the opportunity to gain a broader picture of how training is carried out within the hospital and to identify any points of good practice for sharing more widely.

A summary of the discussions has been compiled under the headings in section 2 below. This report is compiled with direct reference to the GMC's Promoting Excellence - Standards for Medical Education and Training. Each section heading below includes numeric reference to specific requirements listed within the standards.

2.1 Induction (R1.13):

Trainers: The trainers reported that the induction is very comprehensive and managed with excellence by a consultant. Trainees would receive an induction pack prior to beginning in post to review. When trainees attend induction on site, they would receive highly informative talks from the specialty doctor around the core duties of the junior doctor as well as more specialised induction talks from other doctors on site, for example risk assessment training. It was noted that trainees are not oncall in the first weeks until they have completed a full induction to the site. Trainees are also equipped with all the items required to beginning working, for example, a mobile phone, a laptop and access to the necessary IT portals during the first day of induction. The trainers stated that they have sought feedback on the induction programme and have acted upon this feedback to create a more streamlined and balanced programme. The trainers emphasised that if a trainee began in post out with the standard changeover times, then they would ensure that the trainees are directed to the appropriate people for induction to site and be given a full induction. The trainers also noted that any follow up sessions would be given on an individual basis.

Trainees: The trainees reported all receiving an induction to The State Hospital. The trainees stated that induction was well organised and spread out over most of the first week in post. Time was allocated for trainees to meet the team and those they would be working alongside. Although it was noted that there were some communication errors at the recent induction, therefore parts of the induction timings were adjusted. This meant that some sessions has less time dedicated to it, however information was still given and any questions that arose were answered promptly. It was noted by some that although induction was good, it can be improved. It was stated that there are anxieties associated with beginning a post at The State Hospital and it would be helpful if induction included:

- A more detailed overview of the role of the junior doctor on a day-to-day basis,
- Further guidance on completing Care Programme Approach (CPA) documents
- What external opportunities are available to trainees, for example prison clinics
- Guidance on how to approach and complete WBA's at The State Hospital, as there is not a large number of new admissions.

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

Trainers: The trainers reported that there is an understanding that trainees attend their regional teaching on the specific days for the cohort of trainees and trainees are encouraged to attend this. The trainers believe they have a flexible approach to allow trainees to attend both their regional and local teaching. It was noted that there is an awareness of the teaching programme site wide, therefore the specialty grade doctors would hold the bleep to ensure that teaching for the trainees remains bleep free. The trainers described a wealth of local teaching opportunities they provide to trainees that receive positive feedback. The site offers a 'six-part-lecture series,' monthly seminars with the opportunity to present or be presented to. In addition, there is a fortnightly Balint group and 'a new to forensic psychiatry course' that is well structured and trainees receive a qualification certificate upon completion.

Trainees: The trainees reported that there are many local teaching opportunities available. There is a 'six-part-lecture series' and weekly supervision sessions which are both highly rated by the trainees. The trainees also reported that there is 'a new to forensic handbook' that is a guided course with added discussion during supervision meetings. Both core and higher specialties trainees are able to

attend their regional teaching on a regular basis. Some trainees report that on-call commitments can impact the ability to attend the regional teaching, however this is only occasionally. The trainees also noted that they attend the Monday morning medical meeting and this is used a learning opportunity. There is opportunity to present and be presented to at the medical case discussions.

2.3 Study Leave (R3.12)

Trainers: The trainers are supportive of study leave and there are no known issues with approval of study leave.

Trainees: The trainees reported no concerns with accessing study leave.

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

Trainers: The trainers reported that they are allocated to the trainees as soon as the site have an awareness of who will be rotating there. It was noted the timing of this can be variable due to the information being filtered through from recruitment. The trainers emphasised that they are supported to do their role and have access to any information required to be successful in their role. The trainers highlight that there is peer networking support, as well as a good team culture amongst the trainers as a consultant group to support one another. It was stated that there has been much more focus on recognition of trainer status and this has been a supportive avenue to support training as well as develop trainers skills. The trainers have allocated time in their job plan and their role is considered during their appraisal. It was stated that the trainers would be reliant on the local programme lead (LPL) to share any information about trainees who require any support at The State Hospital. The trainers note that they would seek to speak with the trainees and the LPL to either modify or address any concerns during the placement. It was emphasised that this process is well led with effective communication and those with the knowledge of the issues.

Trainees: The trainees reported that they would meet with the educational supervisor on a regular basis. Trainees state that their educational supervisors are supportive and available when required. The educational lead on site will also meet with trainees and ensure that training is going well.

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

Trainers: The trainers stated that following the Deanery quality management visit in 2019, colour coded badges to distinguish between grades of trainees were implemented and still in use on site. The trainers reported that there is a formal day time on call rota and all consultants are easily contactable by the control room, should the trainees need support. Due to the nature of the work on site, the processes would more often require the presence of the responsible medical officer (RMO), therefore, the trainees do not regularly work autonomously or beyond their competence. The trainees however are encouraged to be present on the ward to be actively involved in the cases. The trainers note that they ask for the non-training grade staff members to contact the trainees ahead of the RMO's to expose them to adequate experiences. As there is a frequent need to give consent, the trainees are regularly having discussions and planning within the scope of individual patient needs.

All Trainees: The trainees reported they are aware at all times who is providing clinical supervision both during the day and OOH. The trainees feel that the trainers are supportive and approachable, whilst also ensuring trainees do not work beyond their competence.

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

Trainers: The trainers reported that they are all aware of the curriculum updates and feel they are up to date with all the changes to curriculum requirements. The trainers stated that there is an awareness of being able to balance the exposure to opportunities with both internal and external processes. The trainers noted that the clinical supervisors have a key role in hosting this for individual trainees to ensure the trainees have adequate exposure to all aspects of the job. Although the trainers do state that there is an expectation that they are initiative-taking in seeking out opportunities, for example, the referral services and prison visits. The trainers highlighted that each stage of training have different focal areas, therefore trainers would meet with trainees to focus on areas they wish to develop and look to facilitate these opportunities. The trainers reported that there is a standard list issued at induction that details the consultant areas of interest, and trainees can make relevant contact, to gain further experience in any specific area.

All Trainees: Some trainees reported that there were no particular competencies that they find difficult to achieve. The staff at The State Hospital go above and beyond to support trainees with educational opportunities. Other trainees had concerns about completing ACES prior to ARCP deadlines. Although trainees did feel that opportunities were there, they had to actively seek them out. The trainees reported that the post allowed them to develop skills in managing an acutely unwell patient, but from a core trainee perspective there are less opportunities in this area, due to the nature of the patients and the limited number of admissions. Further concerns were voiced around the administration of completing the many CPA reports as well as minuting the meetings. Some trainees felt that this did not contribute towards their training and there is limited involvement in management decisions of the patient.

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

Trainers: The trainers reported that there were no issues with gaining portfolio assessments. The trainers have not been able to benchmark their assessments against other trainers, but they commented that some sense of this can be gained from the ARCP processes and outcomes.

All Trainees: The trainees reported that there can be issues getting certain WPBA's as described in section 2.6. However, the assessments that are completed are always fair and consistent.

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

Trainers: The trainers reported that there is plenty of formal and informal opportunities to gain experience with the wider staff group. The trainers encouraged trainees to get involved with teaching for the nursing staff. It was highlighted that the feedback from these sessions were positive and the nurses were appreciative of it. The MDT holds regular reflective practice groups that are also attended by the nursing staff. The trainers reported that there is plenty of informal learning together as well as formal learning, as the seminar series is open to all staff to attend.

All Trainees: The trainees reported that there is plenty of exposure to the wider multi professional team as they routinely collaborate closely with one another. It is noted that the team as a whole are all very supportive.

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

Trainers: The trainers reported that there is a well-functioning clinical quality department. The trainees are informed of this at induction and they are encouraged to seek out and make close links with the department. The trainers highlighted that the site has spent 3-4 years developing the quality improvement infrastructure of the hospital and there are staff that have formal QI training. There is a QI forum that trainees can attend and bring any ideas for discussion and be supported by the group. The trainers emphasised that there are plenty of prospects for QI project and many previous trainees have completed excellent projects.

All Trainees: The trainees reported that there is a good established QI team on site and they are supportive of trainees completing quality improvement projects. The trainees noted that they can contribute to the team with ideas of what they are interested in and the team would support the progression of the project.

2.10 Feedback to trainees (R1.15, 3.13)

Trainers: The trainers reported that feedback is given to trainees during their weekly supervision sessions as well as on the ward real time feedback. If there are any issues during out of hours (OOH) this would also be spoken about during supervision although direct supervision would also be available at the time if needed. The trainers state that the ward round setting is an ideal opportunity to get feedback. Trainees are encouraged to be fully involved in the discussion for the management plans for patients, as this is a fantastic way to walk through the decision-making process for patients. The trainers emphasise that they would always be supportive of the trainees throughout.

All Trainees: The trainees reported that they all regularly receive feedback on their clinical decision both during the day and OOH and it is constructive and meaningful.

2.11 Feedback from trainees (R1.5, 2.3)

Trainers: The trainers reported that they seek feedback in the form of a questionnaire on the formal teaching that is provided by the site. The feedback gained from this is fed back to the consultants and used to improve the teaching, as well are any suggestions for future topics. The trainees would also complete an iMatter survey, the line manager would use this feedback and create an action plan to address any concerns raised. The trainers stated that trainees can also raise any concerns via the training committee that is held every 3 months or the medical advisory committee that this held monthly, where there is a standing item for trainee feedback. It was also noted that there is a weekly medical staff meeting where trainee can raise concerns should they wish to. The trainers highlighted that there are both informal and formal avenues for feedback to be given. Trainees are also encouraged to raise any concerns during supervision sessions. The trainers highlighted during the presentation from site that they recently conducted a WeCare survey, following this they have begun to address and implement the improvements suggested from the feedback.

All Trainees: The trainees reported that they can use supervision to feedback any concerns. There is also weekly medical staff meeting and the trainees forum meeting. The trainees stated that any issues that had been raised are being addressed and the communication following has been excellent. It was noted that the issues with the administration of CPA documents has been raised and management are looking to address this with support from the administration team for minute taking purposes.

2.12 Culture & undermining (R3.3)

Trainers: The trainers reported that there are many systems in place to ensure that the trainees are aware of how to raise any culture and undermining issues. The trainees are made aware of the whistleblowing policy and they have access to the wellbeing service. However, the trainers noted that they are mindful to address any concerns as they arise. The trainers highlighted that their behaviours have a functional impact on the training environment to order to maintain a high standard of what behaviours are acceptable. The trainers are not aware of trainees experiencing any comments that were felt to be less supportive or undermining.

All Trainees: The trainees reported that they have not witnessed or experienced any bullying or undermining behaviours. The trainees feel comfortable to approach their clinical supervisor, the

education lead or the consultants if they witnessed any behaviours they deemed to be bullying or undermining. The trainees felt that their concerns would be listened to and addressed in an appropriate manner.

2.13 Workload/ Rota (1.7, 1.12, 2.19)

Trainers: The trainers reported that they believe the rota accommodates for specific learning opportunities as there are many trainers with different special interests and the trainees can approach them at any point to gain further experience in that area. The trainers gave an overview of the rota provision on site during the presentation and it was noted that although there are occasional rota gaps, locums usually fill them quickly. The trainers reported that they are fully aware of the impact on well-being whilst working at The State Hospital. The trainees can be exposed regularly to traumatic stories and patients. Although trainers have developed coping mechanisms, the trainers are fully aware that trainee may feel exposed and triggered by what they are experiencing. To address this the trainees have accessed the psychotherapy consultant to discuss any issues they may be having. The trainers also noted that they try to establish a conducive working environment on site. The trainers feel that by having good access to the trainers both informally and formally establishes a good support mechanism for trainees. There is also a sports club on site that provides a stress release to trainees and create a bond between those on site.

All Trainees: The trainees reported that there are occasional gaps on the rota and they are filled with locums. The site allows trainees first refusal of these shifts, however there is no burden on trainees to fill these gaps. The trainees are able to discuss the rota with the rota co-ordinator easily and were contacted ahead of beginning in post to arrange shifts accordingly. The trainees felt that the workload is manageable and fairly divided. The trainees do not feel that the rota compromises their well-being. However, the policy relating to attending work following an on-call shift where trainees have been called late into the night could be clearer about what time they attend work the following day.

2.14 Handover (R1.14)

Trainers: The trainers reported that handover is informal during the week but will be conducted either face to face, e-mail & use of MS Teams messaging service. At the weekends, a formal handover meeting occurs on Saturday & Sunday mornings at 9am via MS Teams. It was highlighted that there

is a pre-weekend huddle that trainees are invited to attend as well as the weekend handover. There is a 24hr security report that covers mental/physical health issues that are ongoing that trainees would be required to be aware of. The trainers stated that this is emailed every morning at 7am and trainees have access to this.

All Trainees: The trainees reported that there is a daily hospital report sent via email to all staff that contains information from all the hubs. The trainees found this update useful as it highlighted awareness any ongoing concerns with patients and the site as a whole. The trainees noted that if there is anything specific that the trainees would want to handover, they would do this face to face with the junior trainees. Trainees felt that handover is safe for patients, however it is not routinely used as a learning opportunity. At weekends, the trainees reported that there is a pre-weekend handover held on a Friday afternoon via Teams. It was noted that there is some confusion around who should attend this, as it felt that those who were on a day off, still had to attend this. The trainees felt that there should be clarification around who should attend this meeting prior to being on-call over the weekend.

2.15 Educational Resources (R1.19)

Trainers: The trainers reported that there is an excellent learning centre and a library with access to a librarian. The learning centre has satisfactory IT facilities and technology that supports learning.

All Trainees: The trainees reported that they have excellent facilities on site, as there is access to a library and learning centre. It was also highlighted that the trainees felt the access to the Forensic Network was beneficial to them.

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

Trainers: The trainers noted that trainees have local support mechanism in the form of their trainers to discuss and address any concerns they may be having. It was also highlighted that trainees can access the NES trainee well-being service as well as the occupational health service. The trainers report that they provide career support to trainees during their time at The State Hospital and this can

be shown through those who seek employment there following the completion of their forensic training.

All Trainees: The trainees were unsure if the site provides support to those who are struggling with the job, however they have had no experience with this, therefore were unaware of the pathways to follow if there were any issues. However, it was noted that trainees who were working less than full time (LTFT) felt that they have been supported to fulfil their duties whilst working LTFT.

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

Trainers: The trainers reported that they have a clear educational governance structure and this is demonstrated through the use of the forensic network and the committees that are regularly attended by all.

All Trainees: The trainees reported that they would be able to raise concerns with their clinical supervisor and the weekly medical staff meeting has a specific agenda item to raise concerns, as well as giving updates on previously raised issues. There is a local trainee forum for ST trainees and the CT would raise concerns at the monthly meeting.

2.18 Raising concerns (R1.1, 2.7)

Trainers: The trainers reported that there are mechanisms in place for raising concerns and they are used in conjunction with the governance of the site. The trainers noted that concerns would be raised through supervision and escalated appropriately. Any patient safety concerns would usually be resolved locally. The trainers stated that trainees can raise concerns about their education through the education leads on site, clinical supervisors, as well as the LPL's.

All Trainees: The trainees reported that they would raise concerns at their supervision and believe that they would be escalated appropriately as required.

2.19 Patient safety (R1.2)

Trainers: The trainers reported that security is the prime aspect of the State Hospital, therefore trainees are not left alone with dangerous patients and there is a robust system in place to ensure this. The first induction the trainees receive is their safety induction and they will not have direct face to face interactions with the patients until this is completed.

All Trainees: The trainees have no concerns about the quality of care that The State Hospital provides to the patients.

2.20 Adverse incidents & Duty of Candour (R1.3 & R1.4)

Trainers: The trainers reported that trainees would use the DATIX system to report any adverse incidents and trainees are encouraged to input into this system. It is highlighted that there is a robust system of duty of candour and this would link in with the DATIX system. The trainers highlighted that there is a debrief following any serious adverse event, but there is also support available during the Balint groups. Any incident that occurs, will be categorised and reviewed by the trainers. The trainers note that if anything went wrong with patient care, they would always be supported in communicating to the patient affected.

All Trainees: The trainees reported that they have little experience with adverse incidents during their post. However, they are aware that they can use DATIX to submit any concerns and there are local adverse event reviews held following any incidents.

2.21 Other

It was noted during the visit that the NTS red flag referred to in section 1 of this report relates to specialty trainees experience in their local health board and not their experience in the State Hospital.

Summary

Is a revisit required?	**Yes**	**No**	**Dependent on outcome of action plan review**

Positive aspects of the visit:

- The panel felt that the trainers and management engaged with the training and trainees and see training as a priority for the site.
- The trainees appreciated the constructive and useful feedback that is provided to them during clinical interaction as well as during their weekly supervision meetings.
- The trainees expressed that any concerns that are raised are addressed and acted upon appropriately, and the communications following any concerns are given in a timely manner.
- The panel heard that the site has an excellent Quality Improvement team, who provide support and assistance to trainees who are undertaking QI projects.
- There are excellent educational resources on site and the trainees highly value this.
- It was noted that there is ample local teaching opportunities for trainees and it was noted that the '6 series lecture' is well received. The panel heard that there are limited barriers for trainees to attend their regional teaching held in their home board.
- It was strongly felt that all Healthcare staff across the site are a cohesive group, and they all positively engage with one another, to help create a positive working environment.
- The panel noted that the site are flexible to allow trainees to gain experience to further progress their careers.

Less positive aspects from the visit:

- Although teaching is wholly accessible, it would be useful to review the rota to ensure that any potential clashes are addressed ahead of time to allow trainees to attend both local and regional teaching days.
- The panel heard that there should be an awareness of the impact of the new clinical model and the ability of trainees to be able to complete their curriculum requirements if they are designated to only one specific area.
- Trainees felt that being able to timetable clinic opportunities, for example prison visits would enable them to have further training opportunities and complete more WPBA's.
- While induction is comprehensive and robust, trainees would benefit for further clarification around the role of the junior doctor and guidance about completion of CPA's.
- It would be useful to clarify what the arrangements are for the weekend handover and who should attend this meeting.

Areas of Good Practice

Ref	Item	Action
4.1	The provision of the excellent educational resources on site	n/a
4.2	The Healthcare staff across the site are a cohesive group, and they all positively engage with one another, to help create a positive working environment.	n/a
4.3	There is an engaging Quality Improvement team on site and the trainees highly benefit from this.	n/a
4.4	The high quality and amount of local teaching provided is appreciated and valued by all.	n/a

Areas for Improvement

Areas for Improvement are not explicitly linked to GMC standards but are shared to encourage ongoing improvement and excellence within the training environment. The Deanery do not require any further information in regard to these items.

Ref	Item	Action
5.1	The ability to timetable clinic opportunities, for example prison visits would enable them to have further training opportunities and complete more WPBA's.	
5.2	It would be helpful clarify to all trainees who should attend the weekend handover meeting on a Friday afternoon.	
5.3	Further clarification around the role of the junior doctor and guidance about completion of CPA's during induction would be appreciated.	
5.4	There should be an awareness of the impact of the new clinical model and the ability of trainees to be able to complete their curriculum requirements if they are designated to one specific area.	

5.5	A review of the rota and OOH commitments ahead of time will ensure that any potential clashes are addressed ahead of time to allow trainees to attend both local and regional teaching days.	

Requirements - Issues to be Addressed

Ref	Issue	By when	Trainee cohorts in scope
6.1	n/a		

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	26 October 2023
Agenda Reference:	Item No: 13
Sponsoring Director:	Medical Director
Author(s):	PA to Medical & Associate Medical Directors
Title of Report:	Board approval for Approved Medical Practitioner status
Purpose of Report	To approve Section 22 status

1 SITUATION

Following the recruitment of 2 Consultant Forensic Psychiatrists, it is necessary for the Board to consider the approval of their Approved Medical Practitioner status.

2 BACKGROUND

In order for the Consultant Forensic Psychiatrists to perform their full role within the Hospital they require to be approved as an Approved Medical Practitioner (AMP) and placed on the State Hospitals Board for Scotland list of AMPs. An Approved Medical Practitioner (AMP) is a medical practitioner who has been approved under section 22 of the Act by a NHS Board or by the State Hospitals Board for Scotland as having special experience in the diagnosis and treatment of mental disorder.

3 ASSESSMENT

The Consultant Forensic Psychiatrists have completed the pre-requisite Section 22 training in line with the Mental Health (Care and Treatment) (Scotland) Act 2003.

4 RECOMMENDATION

The Board is invited to agree the following recommendation:

The approval of Dr Stuart Doig and Dr Stuart Semple as Approved Medical Practitioners in line with the Mental Health (Care and Treatment) (Scotland) Act 2003 and that they are formally placed on the TSH Board's list of Approved Medical Practitioners.

MONITORING FORM

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

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	26 October 2023
Agenda Reference:	Item No: 14
Sponsoring Director:	Medical Director
Author(s):	Head of Corporate Planning and Performance Clinical Quality Facilitators
Title of Report:	Quality Assurance and Quality Improvement
Purpose of Report:	For Noting

1. SITUATION

This report provides an update to The State Hospital Board on the progress made towards quality assurance and improvement activities since the last Board meeting in August 2023. The report highlights activities in relation to QA and QI and outlines how these relate to strategic planning and organisational learning and development. It contributes to the strategic intention of The State Hospital (TSH) to embed quality assurance and improvement as part of how care and services are planned and delivered.

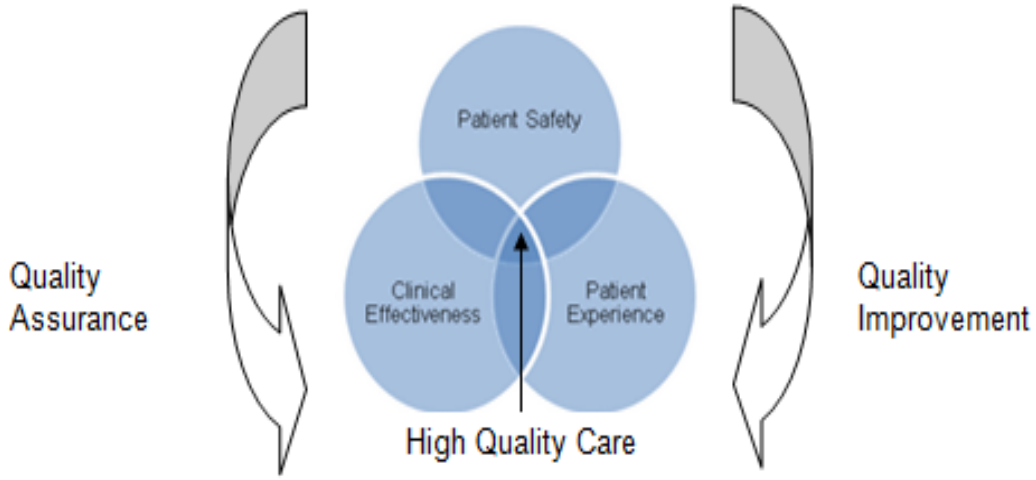
2. BACKGROUND

Quality assurance and improvement in TSH links to the Clinical Quality Strategy 2017 – 2020. TSH will work towards updating and revising the Clinical Quality Strategy in 2023/24 with initial scoping currently taking place. The current Clinical Quality Strategy sets out the direction, aims and ambitions for the continuous improvement of clinical care. It outlines the following seven 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

TSH quality vision is to deliver and continuously improve the quality of care through the provision of safe, effective and person-centred care for our patients and to be confident that this standard will be delivered.

3.



ASSESSMENT

The paper outlines key areas of activity in relation to:

- Quality assurance through:
  - Clinical audits and variance analysis tools
  - Clinical Quality report on analysis of activity data.
- Quality improvement through the work of the QI Forum
- Capacity Building for Quality Improvement
- Realistic Medicine
- Evidence for quality including analysis of the national and local guidance and standards recently released and pertinent to TSH

4. RECOMMENDATION

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

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives?	The quality improvement and assurance report supports the Quality Strategy and Corporate Objectives by outlining the actions taken across the hospital to support QA and QI.
Workforce Implications	Workforce implications in relation to further training that may be required for staff where policies are not being adhered to.
Financial Implications	Not formally assessed for this paper.
Route to Board (Which groups were involved in contributing to the paper and recommendations)	This paper reports directly to the Board. It is shared with the QI Forum
Risk Assessment (Outline any significant risks and associated mitigation)	The main risk to the organisation is where audits show clinicians are not following evidence based practice.
Assessment of Impact on Stakeholder Experience	It is hoped that the positive outcomes with the service level reports will have a positive impact on stakeholder experience as they bring attention to provision of timetable sessions.
Equality Impact Assessment	All the policies that are audited and included within the quality assurance section have been equality impact assessed. All larger QI projects are also equality impact assessed.
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	This will be part of the project teamwork for any of the QI projects within the report.
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One √ There are no privacy implications. □ There are privacy implications, but full DPIA not needed □ There are privacy implications, full DPIA included.

QUALITY ASSURANCE AND IMPROVEMENT IN TSH JUNE 2023

ASSURANCE OF QUALITY

Clinical Audit

The Clinical Quality Department carries out a range of planned audits. Over the course of a year there are usually 25 – 28 audits carried out. These aim to provide feedback and assurance to a range of stakeholders that clinical policies are being adhered to. All clinical audit reports contain recommendations to ensure continuous quality improvement and action plans are discussed at the commissioning group.

Clinical Audits within the hospital have restarted following the implementation of the Clinical Model. The audits completed include:

- Medication Trolley Audit
- Medicine Fridge Audit
- Clozapine Audit
- RMO Record Keeping
- Seclusion Audit

Medication Trolley Audit
The medication trolley audit has been an annual audit which was commissioned through the findings of a Critical Incident Review 2014, following a medication dose error. Following the incident, the standard has been that all medicines should be stored in alphabetical order, with the dose running from low to high. There has been excellent compliance with the standards since they have been in place.

The audit this year identified that 2 wards had achieved 100% compliance throughout the audit. However, concerns were raised in respect of medication order and this was highlighted immediately to the Senior Charge Nurses. Clinical Quality received feedback from some of the wards to assure them that further checks have now been put in place.

Due to the areas of concerns found during this audit, it will be repeated in 3 months time to ensure improvements have been made. The findings will also be discussed at the Medicines Committee in November, with a view to discussing and agreeing recommendations to bring about improvements.

Medicine Fridge Audit
The Medicine Fridge audit was commissioned through the Medicines Committee. This was due to the importance of medications being kept at the correct temperature. The audit looks for assurance of daily temperature checks and logging of these. The findings included improvement required on locating logs in some areas, as well as consistent completion of forms. This will be highlighted to the Medicines Committee to allow them to agree an action to improve this.

Clozapine Audit

The aim of the audit is to ensure current State Hospital practice adheres to NHS Scotland Clozapine Physical Health Monitoring Standards (Feb 17).

Areas of Good Practice included:

- Overall we see improvement in the monitoring of the physical health of patients being treated with Clozapine.
- The average number of checks completed per patient at baseline increased from 7 in both 2019 and 2020 to 10 in 2023.
- During the initiation phase, there was an increase to 100% in Troponin T and CRP in Weeks 1 and 3.
- There was an improvement in all checks in 2023 for 3 months and 9 months. There was an increase in all checks at 6 months with the exception of pulse, which was a slight decrease.
-

Areas for Improvement

- Improve paperwork for initiation stage in line with the national standard for monitoring the physical health of people being treated with Clozapine.
- Monitoring of Bowel Functions.
- Monitoring of Side Effects.
- Improve Baseline Monitoring

Both areas of good practice and areas for improvement will be discussed at the Medicines Committee in November with an improvement plan being agreed.

RMO Record Keeping

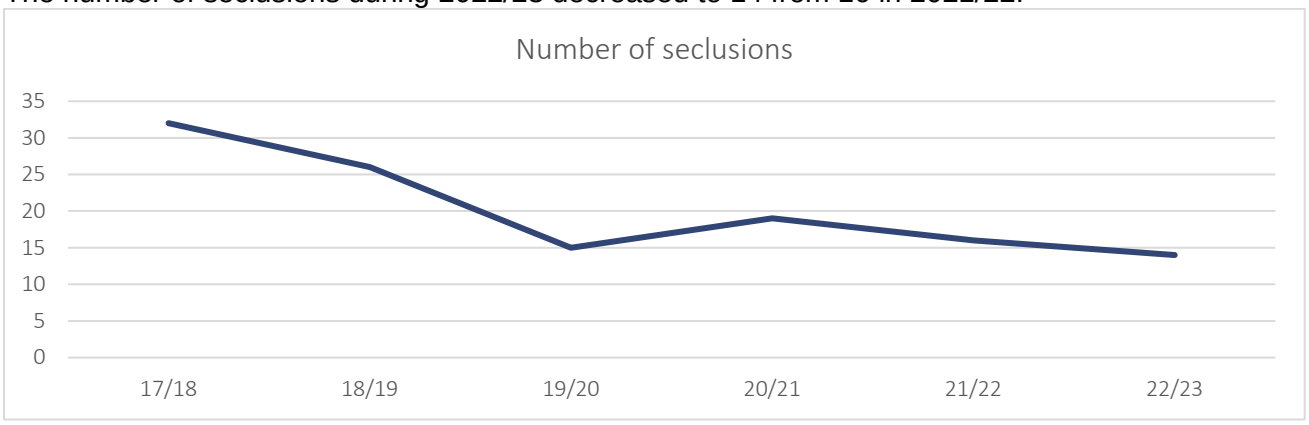
The RMO record keeping standard is that all patients should be seen, or attempted to be seen, by their RMO at least once per month, with a note of this being made on RiO. The August progress notes were interrogated, with 98 out of 103 patients being seen by their RMO in August. It should be noted that 3 of the patients that had not been seen are being cared for by an RMO that had to take leave at short notice.

Clinical Quality were content with these results.

Seclusion Audit

This audit was commissioned by the Patient Safety Group to ensure that staff are adhering to the Seclusion Policy within the hospital.

The number of seclusions during 2022/23 decreased to 14 from 16 in 2021/22.



Areas of Good Practice included:

- In general, the seclusion forms were well completed – however, it is important that all Medical and Nursing interventions associated with the policy are completed and recorded on RiO.
- All seclusions in the audit period had a seclusion notification form completed.
- On the 8 occasions where the junior medical review Appendix 4a/4b had been completed they were carried out within 2 hours of the seclusion commencing and in person as stated in the policy.
- The notification of seclusion ending form was completed on all occasions.

Areas for improvement included:

- The primary review should be completed by Senior Clinical Cover within 30 minutes of commencement of seclusion. On 3 occasions, there was no evidence that a primary review had been carried out. Although this is an improvement from 4 in 21/22 improvement still possible.
- In 22/23 a total 125 of 155 (80.6%) reviews were recorded on Appendix 3. After an improvement in 20/21, there has been a decrease in Appendix 3 completion in the last 2 years.
- On 8 (57.1%) occasions, there was evidence that the first junior medical review had been carried out on the appendix 4a/4b form. On 2 occasions, the review was not required as the RMO carried out the primary medical review.

- Of the 14 seclusions on 7 occasions, Appendix 5a/b was completed (50%). This is a significant decrease from 21/22.
- In 3 cases there was no clear evidence on RiO, that the RMO had interviewed the patient in advance of the seclusion ending.

The Patient Safety Group will agree an action plan for this audit with continuous monitoring by Clinical Quality.

Variance Analysis Tool (VAT) – Flash Reports

Flash Reports were introduced in October 2022 to provide a quick overview of the areas within the VATs that are either improving or showing concern. The following report shows information on August 2023 data.

Overview and areas of good practice

This report refers to all annual and intermediate reviews held across the hospital in August 23.

The monthly VAT report is split as follows:

August 23	Annual	Intermediate	Total	VAT completion
Admission	1	2	3	95%
Arran T & R	3	2	5	95%
Lewis T & R	3	1	4	97%
ID	1	1	2	100%
Transition	3	0	3	93%

In addition data on Admission Case Reviews will be reported to the Admission and Assessment Service and on Discharges to the apporopiate service.

Overall VAT form completion was good at 95%

- Provision of the Dietetic report remained at 100%.
- Provision of the Pharmacy report increased from 79% to 94% and attendance increased from 50% to 59%.
- Psychology completion remains at 100% for the 3rd month running.
- Provision of Skye Activity Centre reports was again 100%
- Provision of Social Work reports remained at 100%

Areas of concern

Medical Completion of the VAT form continues to be an issue with no sustained improvement since the move to the new Clinical Model. Clinical Quality meet with Trainee Psychiatrists when they start their rotation to explain the VAT process. Should medical division put in other contingency plans for VAT form completion? The following table shows individual service completion for Medical interventions. It should be noted that when VAT forms are not completed Clinical Quality do interrogate RiO to gather information on Medical input to the CPA process.

Service	June 23	July 23	Aug 23
Admission	n/a	91%	58%
Arran Treatment and Recovery	96%	78%	64%
Lewis Treatment and Recovery	100%	100%	83%
ID	61%	100%	100%
Transition	70%	100%	70%
Total	86%	92%	71%

Mental State and Physical Health Review - VAT form completion had an impact on these interventions however it should be noted that Clinical Quality checked on RiO for these interventions when the VAT form was not completed and evidence of the Medical CPA report could not always be found on RiO.

Nursing – discussion of the report with the patient prior to the review further decreased from 91% (June 23) to 86% (July23) and is now 77% in Aug 23 - this was due to VAT form non completion.

Key workwer/Associate Worker attendance further decreased from 64.3% to 59%.

Provision of the Psychology Report decreased from 100% to 82%.

Security attendance remained at 29% in the main due to annual leave and shift rota

Any challenges with the systems that are being addressed

Ongoing VAT review looking into obtaining assurance data direct from RiO.

Nursing – The following sub-headings are now available in RiO. These should be used when noting in progress notes the nursing report is discussed with the patient prior to their case review and when the outcome of the review is discussed with the patient. By using these subheadings, it will be easier for nursing staff to locate the date of the progress note when completing the VAT and going forward this is how VAT data will be collected direct from RiO.

- ☐ Post CPA - Nursing Patient Discussion
- ☐ Pre CPA - Nursing Report Discussion

The below table compares the data collected from the VAT and the data collected direct from RiO. As can be seen there is a discrepancy between these 2 figures and individual wards will be notified in order to seek improvement.

Aug 23	VAT forms	RiO –sub headings
Pre CPA – Nursing Patient Discussion – progress note sub heading	77%	35%
Post CPA – Nursing Patient Discussion –	77%	59%

progress note sub heading			

Clinical Quality Flash Reports to Activity Oversight Group

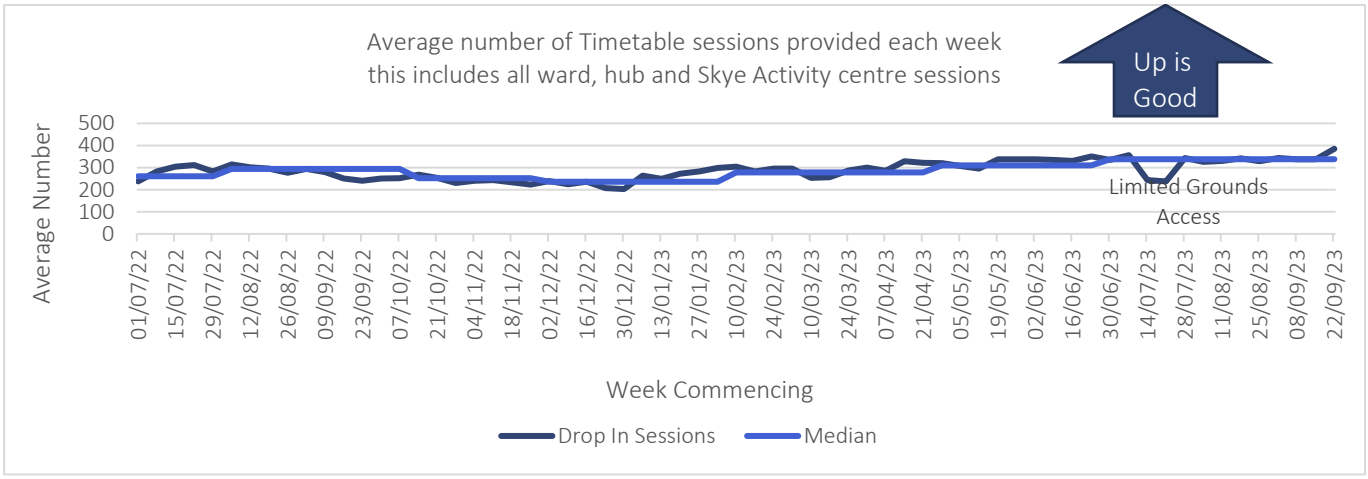
The Activity Oversight Group took over the role of monitoring the activity data last year. Clinical Quality provide a flash report for each meeting that highlights areas of improvement, concern and any system issues. The most recent report is below and will be reviewed by the Activity Oversight group at its next meeting.

CLINICAL QUALITY FLASH REPORT

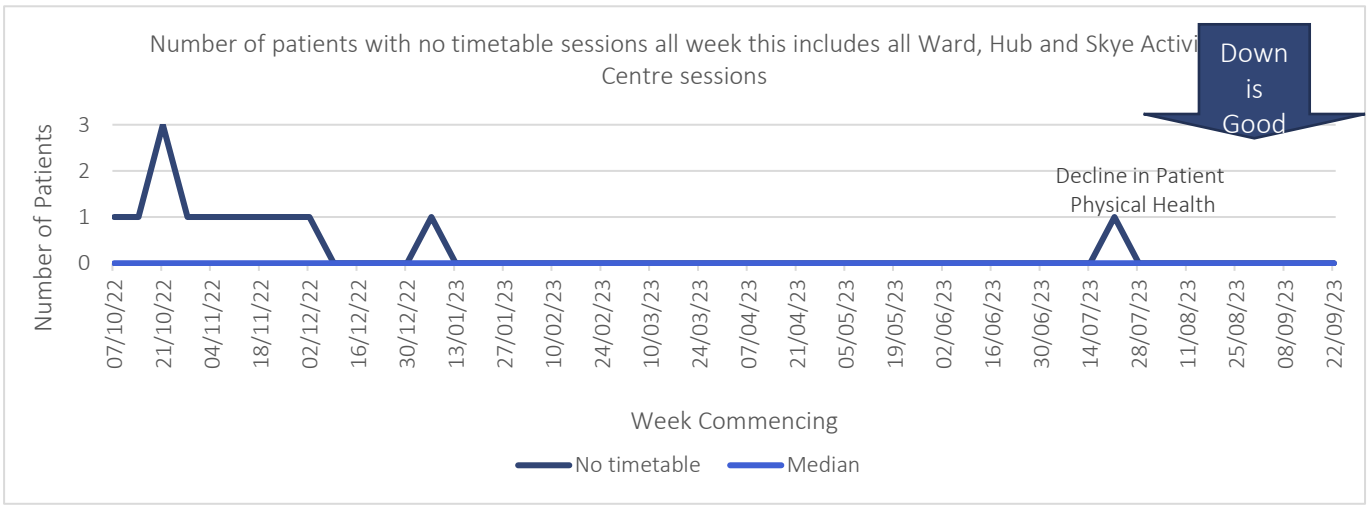
Date: October 2023

Data showing improvement

The graph below shows an increase in the average number of timetable sessions provided each week across all wards on the hub and in the Skye Centre.

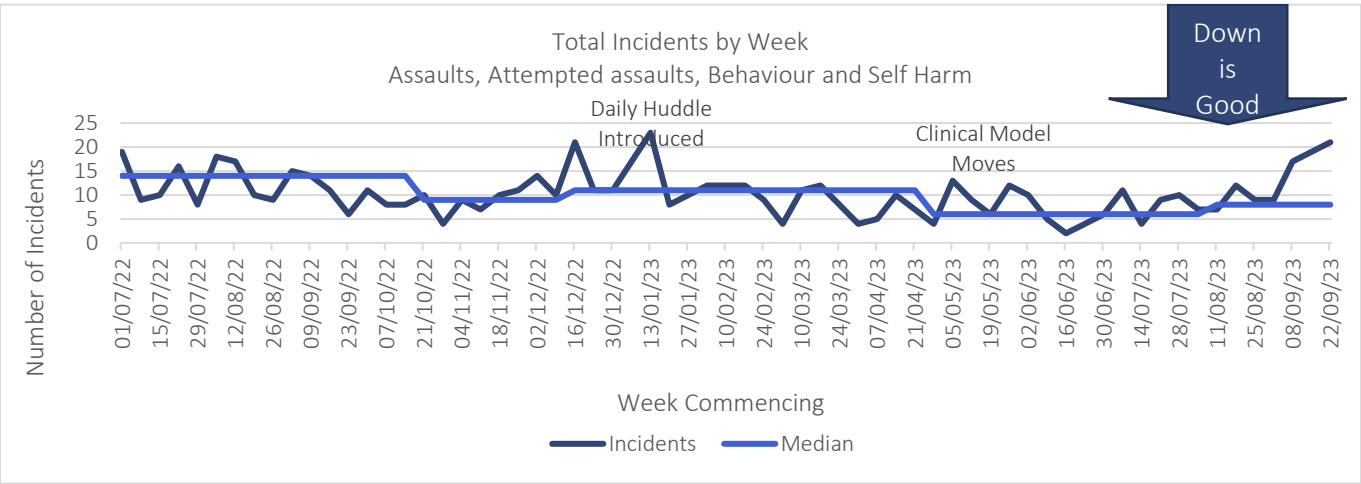


The following graph shows the number of patients with no timetable sessions in a week. This has been positive throughout the year with the only increase due to a decline in patient's physical health.

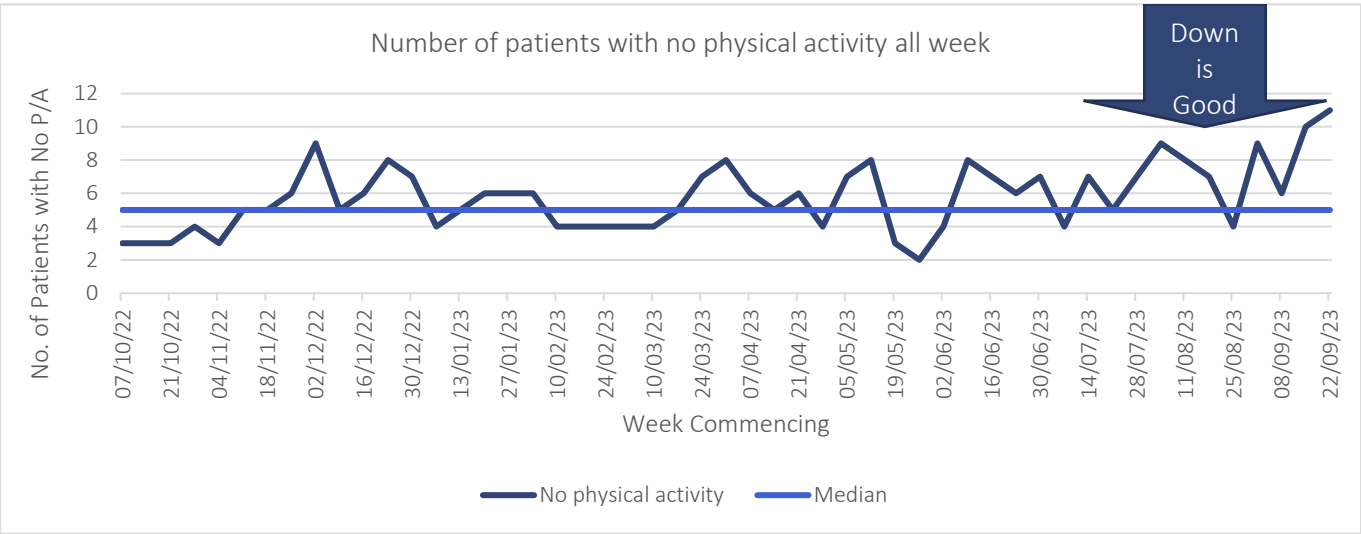


Data showing concern

The graph below shows an increase in incidents in recent weeks. Although there has been random variation throughout the year, we did see the incident numbers drop after the introduction of the daily huddle and the clinical model moves had taken place. Incidents have increased from 9 in the week commencing 1st September 2023 to 21 in the week commencing 22nd September 2023. The majority of these incidents have taken place on Iona 2 and were attributed to poor mental health of two patients. Assurance given that appropriate care and management in place.

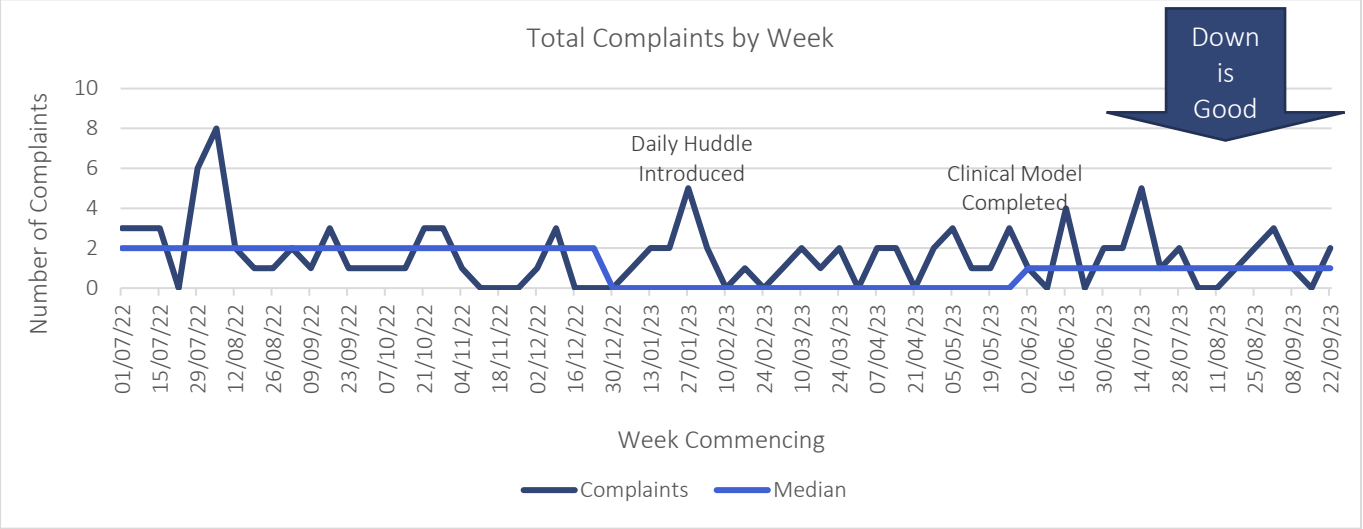


The following graph shows the number of patients who have had no physical activity all week. Due to emergency outings, we have had 3 patients who have attended general hospital and this will have had an impact on the figures being higher than usual.



Areas with sustained levels – random variation

The following graph relates to the number of complaints by week and shows random variation.

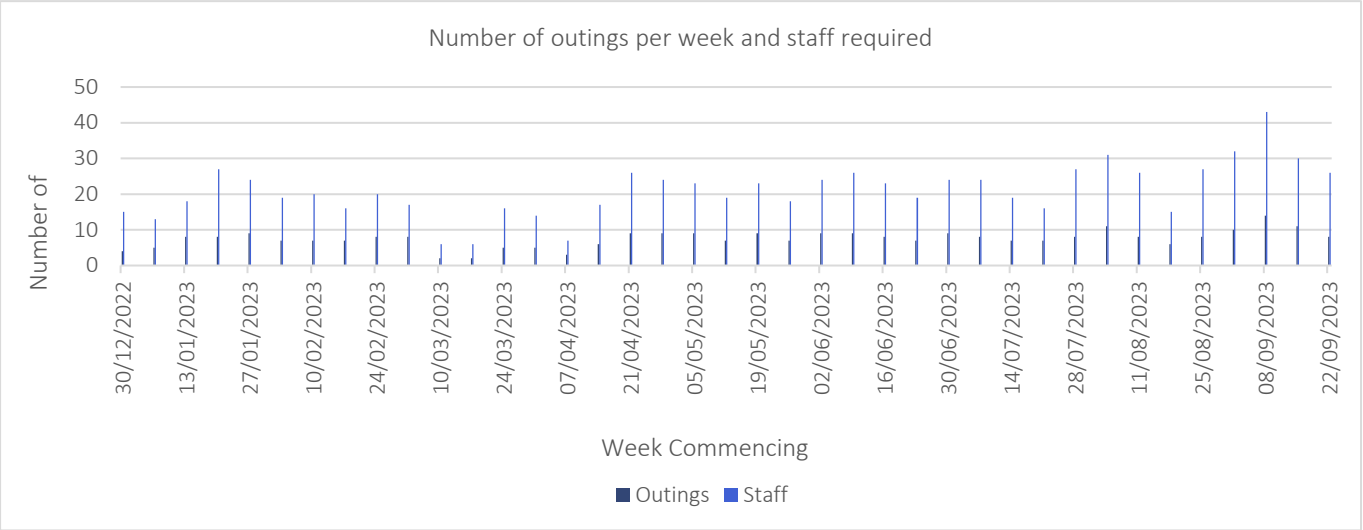


What areas have been worked on in relation to systems

Daytime confinement reporting has begun with posters being shared with each of the services to show the periods of daytime confinement in their areas. Clinical Quality are awaiting feedback on how this data has been presented before making any changes or carrying this work forward.

Any challenges with the systems that need to be addressed

There have been an increased number of patients requiring emergency outings to general hospitals in the last 4 weeks. This is proving to be challenging in terms of staff resources, as there is a higher number of staff required to attend during these emergency outings. This is being addressed as part of the ongoing daily huddle conversations.



Please highlight any support required

Not Applicable

QUALITY IMPROVEMENT

QI Forum

The QI Forum's purpose is to champion, support and lead quality improvement initiatives across the hospital and raise awareness and understanding of QI approaches. The QI Forum met recently and has a focus to raise awareness and build capacity to support and embed QI. A QI projects database has been developed and updated to reflect the range of projects being taken forward across TSH.

QI Capacity Building

QI Essential Training was delivered over 2 days in June to TSH staff, projects are progressing with a project feedback session planned in October. Planning is underway to offer a further QI Essential Training in November / December.

Scottish Improvement Leadership Training (ScIL) is ongoing with 3 TSH staff on current cohort. A further 2 TSH staff have been successful in gaining places on the next cohort of ScIL which will start in December.

The Scottish Coaching and Leading for Improvement Programme (SCLIP) is currently underway with 1 TSH staff member attending.

Realistic Medicine

Realistic Medicine (RM) is the Chief Medical Officer (CMO) 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. In December 2022, Scottish Government published "Delivering Value Based Health and Care" (VBH+C), setting out the vision for VBH+C and reinforcing the RM approach as the vehicle through which VBH+C would be realised.

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 updated Realistic Medicine Action Plan was submitted to Scottish Government in May. A six month progress report was submitted to Scottish Government in September and is included as Appendix 1. The Realistic Medicine Action Plan has been updated for Q2 with progress across the projects noted. Priorities for the remainder of the year include a focus on increasing the uptake of the Shared Decision Making (SDM) module on Turas and supporting approaches to incorporate the BRAN (Benefits, Risks, Alternatives and do Nothing) questions within the high secure forensic setting.

The recruitment process for a new Project Manager to provide support for Realistic Medicine has progressed recently with interviews due to take place in early November. An interim support has also been secured with an internal placement of a staff nurse proving support for the action plan.

Evidence for Quality

National and local evidence based guidelines and standards

TSH has a robust process in place for ensuring that all guidance published and received by the hospital is checked for relevancy. If the guidance is deemed relevant this is then taken to the appropriate multi-disciplinary Steering Group within the hospital for an evaluation matrix to be completed. The evaluation matrix is the tool used within the hospital to measure compliance with the recommendations.

Over a 12-month period, an average of 200 evidenced based guidance documents issued from a variety of recognised bodies and reviewed for relevancy by the Clinical Quality Facilitator. During the period 1 August 2023 to 30 September 2023, 22 guidance documents have been reviewed. There were 19 documents which were considered to be either not relevant to TSH or were overridden by Scottish guidance and 1 document which was recorded for information and awareness purposes. Of the remaining 2 guidelines, one in relation to COPD will require a completed matrix whilst the other is pending a decision regarding the need for a full matrix process.

Table 2: Evidence of Reviews

Body	Total No of documents reviewed	Documents for information	Evaluation Matrix required
Mental Welfare Commission (MWC)	1	1	0
SIGN	1	0	1 Pending
Healthcare Improvement Scotland (HIS)	3	1	0
National Institute for Health & Care Excellence (NICE)	17	0	1

There are currently 6 additional evaluation matrices, which have been outstanding for a prolonged period and await review by their allocated Steering Group. The progress of the first two evaluations from HIS and the MWC was temporarily paused due to TSH adapting to the COVID-19 pandemic however as per Gold Command, action on matrix completion began again at the start of July 2020. The responsibility to review these matrices changed ownership from the PMVA Review Group to the Patient Safety Group, which recommenced meetings in September 2020. Work is progressing with both, with an anticipated completion date of 2024.

The guidance review regarding MS has temporarily been placed on hold pending diagnostic investigations being conducted on 1 patient. The GP and Practice Nurse are aware of the content of the guideline however feel it would be more prudent to work through the content in tandem with the investigation process given that there has been no previous history of any patient with this diagnosis.

SIGN's national guideline for stroke was been delayed due to prioritizing of numerous guideline reviews by the practice nurse and GP. Review of this document has commenced and will be completed early in October 2023 at which point an adapted evaluation matrix will be compiled for review and completion by a wider multi disciplinary team. It should be noted that there are approximately 530 recommendations within this document which required to be reviewed given that only a few may be relevant to TSH.

The content of the Clinical escort guidance for patients receiving ECT as an inpatient is currently under review whilst the final evaluation matrix regarding Care of deteriorating patients from SIGN is being typed up by Clinical Quality and once this has been completed will be presented to the PHSG for final agreement and sign off.

Table 3: Evaluation Matrix Summary

Body	Title	Allocated Steering Group	Current Situation	Publication Date	Projected Completion Date
HIS	From Observation to Intervention: A proactive, responsive & personalised care	Patient Safety	Evaluation matrix completed with 28 outstanding recommendations Patient Safety meeting took place mid-September.	Jan 2019	January 2024

Body	Title	Allocated Steering Group	Current Situation	Publication Date	Projected Completion Date
	& treatment framework for acutely unwell people in mental health care		Policy continues to undergo extensive review with projected implementation date is January 2024.		
MWC	The use of seclusion	Patient Safety	Work ongoing. Release of updated Seclusion Policy currently on hold due to ongoing work with Clinical Care Policy with seclusion tier 1 and 2 being incorporated. Both policies to be launched together. Implementation date is January 2024	Oct 2019	January 2024
NICE	Multiple sclerosis in adults: Management UPDATED	PHSG	Previously reviewed in Oct 2014 when recorded for information purposes only. Given that TSH had no patients with an MS diagnosis PHSG agreed that should this change, the guideline would be used. Current 2022 situation was same however there is now 1 possible diagnosis pending with patient on waiting list for further investigation. Completion of matrix placed on hold until outcome of referral. Patient currently 35 weeks into a 60 wk waiting time.	June 2022	2023 Awaiting outcome from specialist referral (March 2023)
SIGN	National Clinical Guideline for Stroke	PHSG	CQ and Practice Nurse meeting to review content as it contains over 530 recommendations which will not all be relevant to TSH. Meetings held and identifying of relevant recommendations nearing completion. Final review meeting scheduled for early October prior to adapted evaluation matrix being drawn up and meeting of review group to complete.	April 2023	Dec 2023
PH Scotland	Clinical escort guidance for patients receiving ECT as an inpatient	MHPSG	Content currently being reviewed by sub group with any actions to be agreed. Review delayed due to various members' periods of leave.	June 2023	Nov 2023
SIGN	Care of deteriorating patients	PHSG	Evaluation matrix feedback received. To be typed up and presented to PHSG	June 2023	Nov 2023

Appendix 1

Realistic Medicine Six Monthly Progress Report

Board – NHS The State Hospital

Owner – Gordon Skilling, RM Clinical Lead

Date – 18/9/23

Please provide a short narrative on the progress within your Board, including what has gone well, what you have learnt and anything you wish to share.

Progress has been made in key areas relevant to the TSH RM Action Plan. QI Approaches are being used more extensively across TSH to progress significant areas of core business and increase use of data for improvement.

The new Clinical Model was implemented across the hospital in July 2023. This means that patients are now cared for in services that meet their individual needs in terms of the stage of their recovery journey they are at. Three new clinical services have been set up. Each has a leadership team, supported by our Clinical Quality department who provide a tailored data report for each service. This has already illustrated some potential unwarranted variation in terms of length of stay, tailored security measures and access to activity. These are being further explored.

A major organisational priority in the last quarter, has been to address the use of Daytime Confinement (DTC) in the hospital. QI approaches have been used to understand the problem and devise a strategy to address it. Multiple work streams have been set-up to take forward proposed changes. In addition, a daily morning huddle has been implemented to bring together all disciplines to review and plan staffing across the site to minimise the use of DTC when possible.

Work on the CPA project has progressed, with consultation on a draft revised CPA document underway. The revised approach aims to provide more meaningful, individualised treatment objectives that are derived directly from each patient's individual formulation. The format is more accessible for patients and carers.

We have continued to build our QI infrastructure, with our in-house QI training course ('QI Essentials') being delivered again in July 23 and 7 staff now working on QI projects. A further training course is planned in November /December. We continue to have good uptake of the ScIL training, with 3 staff members active on this training at the moment.

The Supporting Healthy Choices project team have developed a Driver Diagram and Pareto Chart to help focus approaches to the obesity challenge in our patient group.

Please provide a brief description of what work has been undertaken to deliver on funding conditions and what the next step are.

Ensure all health and care professionals in Scotland complete online shared decision-making training available on TURAS;

To date, 66 members of TSH staff have completed the module. This is around 10% of total staff.

The RM Action Plan includes a proposal to engage nursing leaders across the site to drive completion rates. This will be taken forward in the next 6 months.

Ensure that patients and families are encouraged to ask the BRAN questions;

Supporting patients and families via use of the BRAN questions needs further consideration of how these apply in the context of high secure psychiatric care. Much of the treatment we provide is on a compulsory basis. This does not preclude the use of the BRAN approach, or a variation of it.

All of our patients have access to various statutory rights and supports, including Advance Statements, Named Persons and Independent Advocacy. Work is also ongoing as to how we can make our CPA processes (our 6 monthly case conference system) more patient centred. The RM Action Plan includes work to improve access for patients to Independent Advocacy.

Ensure health and care teams begin to evaluate the impact of shared decision-making conversations from their patients' perspectives;

The impact of shared decision making approaches used in planning care will be followed up as an aspect of the changes to the CPA process.

Support local teams to work with the CfSD on full roll out of ACRT, PIR, and best practice pathways, including the EQUIP pathways, as quickly as possible and report uptake.

This area is not relevant to The State Hospital

Ensure local clinical teams engage with the Centre for Sustainability Delivery to consider current and future Atlas of Variation data to help identify unwarranted variation in health, treatment, service provision or outcomes and demonstrate how the board can improve.

There are no current Atlases relevant to The State Hospital

What are your key objectives for the rest of the financial year?

- To continue to progress the individual projects within the Realistic Medicine Action Plan.
- Reduce use of DTC.
- Continue to support and progress the bedding in of the new Clinical Model.
- Understand and address unwarranted variation and use of data to drive decision making.
- Embed QI approaches.
- Progress work on BRAN questions
- Increase completion rates of SDM module.

What can the Policy team support you further?

Nil specific

Is there anything else you wish to share?

Nothing currently

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	26 October 2023
Agenda Reference:	Item No: 15
Sponsoring Director:	Director of Workforce
Author(s):	HR Advisor / Training & Professional Development Manager / Head of HR
Title of Report:	Staff Governance Report
Purpose of Report:	For Noting

1 SITUATION

This report provides an update on overall work within the Workforce Directorate. This report encompasses all the updates in one rather than the numerous papers in the past.

Information and analysis is provided quarterly to the Staff Governance Committee and Bi-monthly to the Board. Monthly reviews also take place at the Workforce Governance Group, the Operational Management Team and Corporate Management Team. Information is also provided on a monthly basis to the Partnership Forum and HR & Wellbeing Group.

2 BACKGROUND

The Workforce Directorate consist of HR, Learning, Training & Development and Occupational Health Services.

The Teams work closely together to support Managers and Staff within TSH on a number of key areas and this report details the background and update for each Department.

It was agreed by the Board that the reports should be amalgamated into one regular update.

3 ASSESSMENT

HR UPDATE

Absence and Attendance Management

The below tables provide a breakdown of absence percentage per month both hospital wide and by nursing wards.

Hospital Wide

Month	Short Term	Long Term	Total
July	2.15%	6.63%	8.78%
August	2.45%	6.08%	8.53%
September	2.25%	4.83%	7.08%
YTD	1.92%	6.25%	8.17%

Nursing focus

Month	Short Term	Long Term	Total
July	2.18%	9.18%	11.36%
August	3.94%	8.14%	12.08%
September	3.26%	6.88%	10.14%
YTD	2.37%	8.26%	10.63%

Training/ Support

- The HR team continue to support line managers and offer guidance.
- Work is prioritised within the task and finish group and HR will support action plans for the areas with the highest absence; Nursing, Skye Centre, Housekeeping and Security.
- Attendance Training specific for Charge Nurses continues and was last held on 26 July 23. Eight Charge Nurses attended, bringing total Charge Nurses who have attended this training to 17. The topics covered in the training include current absence costs within the state hospital, holding a meaningful return to work interviews, awareness of the range of support and reasonable adjustments.
- Attendance training is continuing to take place for all managers and staff side representatives within the hospital. 30 managers have attended to date. The next session takes place on 1 December 2023. The topics covered in the training include application of the Attendance Policy, absence reporting, holding meaningful absence meetings, return to work discussions, occupational health referrals and employee assistance.
- Implementation of the Occupational Health contract continues and is an initial 5-month review was undertaken in on 31 August. Key areas of focus for the next 6 months are:
    - engagement & attendance with the service,
    - focus on KPIs particularly referral to report (15 days)
    - immunisation and health surveillance status and legal compliance
    - EOPAs implementation and opportunities arising from that.

Attendance Management

The below table provides information on how many staff were placed on a period monitoring during each month and the total number of staff actively on a live monitoring period.

Month	Stage 1	Stage 2	Stage 3	Total staff in month under monitoring
July	10	2	0	65
August	14	4	2	74
September	12	4	0	79

- The HR department continue to audit compliance with the policy monthly and escalate to line managers or Heads of Department as required, For example:
- In August, there were 35 'End of Stage Meeting Reviews' which HR had no record of taking place. Highest areas of no records held are;
  Skye Centre – 12
  Arran – 4
  Iona – 4
  Lewis – 4
  Health Records – 2
- Improvements were seen during September and is now at 25 with Skye Centre seeing the biggest improvement. It is essential that these take place, are recorded and sent to HR to ensure that the employees are supported to remain healthy at work and ensure policy compliance.
- From the time reports are pulled on Tableau, 25 Return to Work Interviews were outstanding from July, 19 for August and 21 for September. These numbers reduce throughout the month however reports are produced and sent to managers at the start of the new month reminding them to undertake a quality return to work interview and ensure SSTS has been updated to reflect this. Return to Work Interviews should take place within two days of a return to work.
- Dedicated support is being provided by HR for 2 x Stage 3 meetings in August, where consideration of employment was required.

Absence Reasons

- Key reasons for short-term absence were anxiety/stress/depression, cold/cough/flu, chest / respiratory problems, back problems, injuries/fractures and gastrointestinal.
- Key reasons for long-term absence, were anxiety/stress/depression, musculoskeletal, injury / fracture and back problems

Recruitment

Adverts

- 11 separate posts were advertised in July, 6 in August and 8 in September, totalling 26 vacancies.
- Between July and September there were 29 individuals with conditional offers pending pre-employment checks.

Time to Hire

- Throughout the year, Time to Hire has improved with the exception of July (120 days) and August (154 days) this was due to the Registered Nurse post having staggered start dates linked to dates for achieving registration.
- For September, the board Time to Hire was 85 days. The KPI is 75.
- Work continues to bring Time to Hire KPIs in line with national KPIs and positive changes have been noted throughout 23/24.

- Areas for celebration include closing date to shortlisting complete which is 4 days showing that hiring managers are shortlisting timeously and conditional offer to pre checks complete which shows checks are being completed faster by the Human Resources team.
- Some areas which require improvement is invite to interview to interview, the national KPI is 7 days, TSH is 12 days. Recommended improvements to this KPI would be to only provide 7 days notice of interview for candidates.

Recruitment and Retention Strategy

- The actions from the strategy are being taken forward in accordance with the work plan and will be reported going forward through the Workforce Governance Group.
- Feedback from on-boarding surveys which were sent to staff who started from 2022 at 3, 6 and 12 month junctures have been presented to Organisational Management Team and an action plan devised for managers to use within their teams, to reflect on the feedback received and provide update to OMT in December 2023.
- The first Recruitment Training session for Hiring Managers took place on 30 August 2023 which covered legislation, advertising, shortlisting, interviewing and onboarding. This was attended by 6 managers.
- The next Recruitment Training session for Hiring Managers covering legislation, advertising, shortlisting, interviewing and onboarding is scheduled for 5 December 2023.

Supplementary Staffing

Overtime and Excess Hours

The tables below show supplementary staffing required through overtime or excess hours for the whole organisation and nursing as WTE.

Hospital Wide

Month	**WTE**
July	46.98
August	44.78
September	55.58

Nursing Wide

Month	**WTE**
July	28.33
August	25.42
September	36.92

Supplementary Staffing Register – Nursing

The below table shows hours and Whole Time Equivalent (WTE) used from the Nursing Supplementary Staffing group between July and September.

Month	Band 3 Hours	Band 5 Hours	Total Hours	WTE
July	146	968	1,383	8.33
August	369	1,455	1,813	10.92
September	385	1,259	1,644	10.23

- As of September 2023, 30 Supplementary Staffing Register (SSR) contracts were in place, with 8 x band 3 Nursing Assistants and 22 x band 5 Registered Nurses.
- Work will be overseen by the Workforce Governance Group on analysing the use of overtime / excess hours and all supplementary staff.

Employee Relations

ER Case Work

- As of the end of September 2023, there were five ongoing cases, two of which have been ongoing for more than six months.
- In respect of the two which have been ongoing for six months, investigations are complete and are with the commissioning manager for consideration of next steps which will bring these to a conclusion.
- During August one case concluded with a timescale of six months and during September two cases were concluded with timescales of 16 weeks. The timescales for September were affected by annual leave / summer holidays and logistics of interviewing witnesses due to planned leave and sickness absence.
- Focus remains on quality early resolution for employment relations cases where appropriate.
- Training is currently being developed for investigation managers as well as for panel members.
- A new SOP is in place to ensure that employees and other affected individuals are communicated with and offered support at regular junctures during the process.

Turnover

The below table provides information for leavers for 2023 and 2022 for comparison.

Month	2023	2023 YTD	2023 Turnover %	2022	2022 YTD	2022 Turnover %
July	4	16	2.30	8	26	3.13
August	2	18	2.82	7	35	4.30
September	14	32	4.46	5	40	5.09

- Two leavers in September returned to SSR due to joining university for healthcare studies (nursing and psychology).
- One leaver in September was a NES Trainee and has secured a permanent Clinical Psychology within the State Hospital. This is encouraging in terms of retention.

Exit Interviews

- Exit interviews continue to be offered to all staff on leaving the organisation at the time of resignation letter received to HR. A Leavers Letter is also sent to home address containing a QR code to the Exit Interview online link.
- 11 out of 32 leavers YTD have completed the exit interview which brings the total number of electronic exit interviews to 21 since commencement in November 2022.
- To improve this uptake the invitations will be copied to line managers to encourage participation during notice periods.

Job Evaluation

Status / Progress for July, August and September

- 10 job descriptions were received; 5 new posts; 4 posts requiring an update due to terminology changes; and 1 significant change post
- There were no requests for a review received.
- A total of 6 job evaluation matching panels took place and 2 quality check panels.
- There have been 7 posts who have received an outcome.

Status

- There are now 9 posts for consideration.
- Of the 9, one requires full Job Analysis and a date has now been arranged to progress this.
- The JE Leads continue to meet monthly to ensure timely progression of posts.

Job Evaluation Steering Group

- It was agreed that a suite of local training resources for managers to develop their skills in writing Job descriptions and understanding of the JE process, will be designed based on information which is available nationally. This will be delivered for the State Hospital in the next 12 months.
- The JE Leads will create a succession plan for the JE practitioners, due to the reliance on key individuals and risk to the organisation should they become unavailable, noting also the risk due to unavailability of national training which is required to participate in the process.

eRostering

eRostering is well underway and Teams are currently working through their rosters. There is a plan in place to go through the Hubs and supporting the Teams on using the new system moving forward. It is planned that this will be fully implemented by 31st March 2024.

There are 4 stages to the implementation which are Initiation, Readiness, Deployment, Adoption and Realisation. We are currently in Deployment and will move to Adoption in May before moving to Realisation by end of March 2024.

The introduction of this new system will offer an opportunity for data to be analysed and viewed at a glance by the Line Managers. They will be able to see any set patterns and highlight this to staff. This includes absence after pay day, weekend absence, public holiday absence or indeed absence just prior to or after a period of annual leave. This will enable Managers to consider areas of concern.

Learning, Training & Development

PDPR Compliance

In line with national targets, a key priority within the State Hospital's Staff Governance Action Plan is to ensure that all staff have an annual Personal Development Planning and Review (PDPR) meeting with their line manager.

As at 30 September 2023:

- The total number of current (i.e. live) reviews was 515 (85.1%) – an increase of 2% from 31 July 2023.
- A total of 80 staff (13.2%) have an overdue review – a decrease of 1.1% from July 2023
- A further 10 staff (1.7%) have not yet had a review meeting – a decrease of 0.9% from July 2023. Staff in this group are predominantly new staff with an initial set-up review meeting overdue.
- There are currently twelve departments below the State Hospital's 80% minimum compliance threshold (a decrease of two from last month).
- Progress reports continue to be provided to all departmental managers on a monthly basis, and compliance levels are monitored and reviewed quarterly by the Organisational Management Team.
- There were 8 departments below the State Hospital's 80% minimum compliance threshold (a decrease of 4 from July 2023).

Progress reports continue to be provided to all departmental managers on a monthly basis, and compliance levels are monitored and reviewed quarterly by the Organisational Management Team. Departmental compliance is also monitored at Directorate Quarterly Performance Review Meetings with the Chief Executive.

iMatter

The 2023 iMatter has now been completed and we are awaiting the publication of the national report, which is Scottish Government are saying they are working towards publication by the end of November. This will allow for further data comparison to be carried out and it is anticipated this will be presented to the Board at their December meeting.

The OD Manager has recently completed a thematic analysis, at an organisational level, of the teams' actions plans, focusing on how teams intend to take forward their actions. Support is now available to assist line managers in implementing their plans, working with them in areas such as team development.

Coaching

There are three internal trained coaches who provide coaching for TSH workforce and work as part of a collaborative coaching network across the West of Scotland.

- We have one member of TSH staff being coached internally by TSH coaches.
- We have one TSH members of staff waiting to be matched by a NHSL coach.
- We have three TSH members of staff being coached by an NHSL coach.
- We have one external staff member being coached by a TSH coach.

Coaching for Wellbeing continues to be available for all H&SC staff across Scotland and registration for this can be accessed via the National Wellbeing Hub.
In addition, two managers from the State Hospital commenced the Advanced Certificate in Coaching Practice (ACCP) course in September 2023. Completion of this accredited learning programme will help to increase internal capacity to provide coaching support to managers and staff.

Peer Support Network

The Peer Support Network was officially launched during week commencing 18th September. A framework to support implementation and ongoing development has been developed and was recently endorsed by the Partnership Forum.

Updates on its progress will be contained in future reports.

Wellbeing

The Wellbeing Centre continues to be available for all staff to access 24/7, as and when required (including before, during or after shift). There is dedicated support available within the Centre Monday–Friday, 9am-5pm. Data on use of this facility is obtain through sampling, with footfall monitored and recorded once per quarter and reported to the HR and Wellbeing Group.

In addition, the Staff Care Specialist service provision remains in place via a SLA with NHS Lanarkshire (NHSL). Two Staff Care Specialists (Graeme Bell and Patricia Johnston) each provide support for one day per week. This is on a temporary basis and there are plans, pending a recruitment process facilitated by NHSL to have in place a new Staff Care Specialist from early November. Graeme and Patricia will continue to provide support, so there is the continuity of the service provision.

The Wellbeing Activity updates for September and October (to date) is attached in Appendix 1

As part of the ongoing improvements associated with the Staff and Volunteer Wellbeing Strategy, an evaluation will be carried out during the period from September 2023 to March 2024.
This will include –

- Capturing quantitative data against each of the aims, specifically in terms of the Wellbeing Centre outputs
- Evaluating how the aims of the strategy have been achieved against the established KPIs
- Through qualitative inquiry, determining the impact of the Wellbeing Centre activities

A research proposal has been developed and it is anticipated this will be considered by TSH's Research Committee at its November meeting.

4 RECOMMENDATION

Board Members are invited to note this report and the updates.

MONITORING FORM

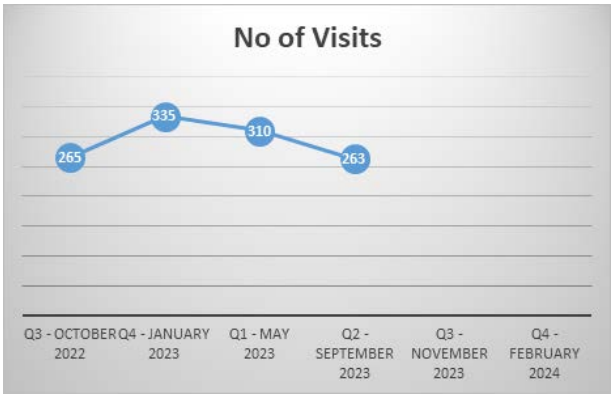
How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Links to the Staff Governance Plan, Attendance Management Policy, Mandatory / Statutory Policy.
Workforce Implications	Failure to achieve relevant targets will impact ability to efficiently resource organisation.
Financial Implications	Failure to achieve 5% sickness absencetarget results in additional spend to ensure continued safe staffing levels
Route to Board Which groups were involved in contributing to the paper and recommendations.	Corporate Management Team, Staff Governance Committee, Workforce Governance Group, Partnership Forum, HR and Wellbeing Group
Risk Assessment (Outline any significant risks and associated mitigation)	Fully outlined and considered in the report
Assessment of Impact on Stakeholder Experience	Failure to achieve the set targets will impact on stakeholder experience
Equality Impact Assessment	Not required for this report as monitoring summary report.
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	There are no identified impacts.
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One X There are no privacy implications. □ There are privacy implications, but full DPIA not needed □ There are privacy implications , full DPIA included.

APPENDIX 1

WELLBEING ACTIVITY UPDATE

The table below demonstrates and provides an update on the activity being undertaken across the key areas and also includes the work of the HWL Group:

SELF HELP INITIATIVE	Activity	Dates	Update (attendance, progress)
Workplace Relaxation Complimentary Therapies	Opportunity for staff to access alternative therapy to help reduce stress, anxiety, musculoskeletal issues	28 September 2023	44 staff accessed a massage session
Relaxation and Mindfulness	Relaxation sessions	20 September 2023	3 staff attended
Coffee, Cake & Conversation	'Wellbeing Outreach' Opportunity to take wellbeing hospitality and support to areas where staff have challenges attending the wellbeing centre	September/October 2023	2 sessions held on MS Teams for hybrid workers- (12 staff attended) 1 session in Arran- (8 staff attended) 1 session in Iona- (26 staff attended)
Badminton Lunch time Club	Staff meeting at lunch time for a game of badminton	19 September 2023 (for 10 weeks)	Average 6 staff attending each week
Yoga	Lunchtime session for staff	12 October 2023 (for 10 weeks)	15 attended first session
MacMillan Coffee Morning	Annual fundraiser for Healthy Working Lives Group	29 September 2023	£361.00 raised on the day

Wellbeing Centre Footfall	Record of staff visiting and using the wellbeing centre	1 – 30 September 2023 - **263 staff** 	
PEER SUPPORT INITIATIVE	**Activity**	**Dates**	**Update (attendance, progress)**
1:1 Referrals from staff	Staff care specialist one to one meetings with staff	September 2023	2 new referrals (current caseload = 4)
Peer Support Network	Launch of Peer Support Network	September 2023	PSN launched on 18 September
LINE MANAGEMENT INITIATIVE	**Activity**	**Dates**	**Update (attendance, progress)**
Coaching Skills and Courageous Conversation Workshops	Development opportunity for managers and leaders	October 2023	4 staff attended the first workshop 25 staff attending over two sessions planned for November
ORGANISATION INITIATIVE	**Activity**	**Dates**	**Update (attendance, progress)**
Cycle to Work Scheme	Cycle scheme to support staff and volunteers	1 May 2023 - Ongoing	12 staff have signed up since launch in May
Suicide Awareness Day	Chris House Promotion and Awareness	4 – 10 September 2023	Health promotion stand in the wellbeing centre and at security reception to raise awareness around suicide prevention

Electrical Vehicle Scheme	Salary sacrifice scheme similar to cycle scheme	12 September 2023	NHS Fleet Services attending HR&W Group on 12 September
Speak Up Week	Raising awareness of whistleblowing	2 – 6 October 2023	Promotion stand in wellbeing centre and at security reception Word-search competition – 67 entries received
Long Service Awards	Staff recognition awards	7 December 2023	50 staff will receive a long service award this year at a presentation on 7 December 45yrs – 2 special awards 40yrs – 5 30yrs – 11 20yrs – 32
Time for Talking Service	Counselling support for staff	12 September 2023	Attended HR&W Group to raise awareness of service

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	26 October 2023
Agenda Reference:	Item No: 16
Sponsoring Director:	Director of Nursing and Operations / Director of Workforce
Author(s):	Senior Nurse Workforce Planning / eRostering Project Manager
Title of Report:	Implementation for Health and Care Staffing Act/ eRostering Update
Purpose of Report:	For Noting

1 SITUATION

The Health and Care (Staffing) (Scotland) Bill was passed by parliament on 2 May 2019 and received Royal Assent on the June 6, 2019. Statutory Guidance Chapters have been developed in conjunction with Health Improvement Scotland (HIS) and are currently being tested out across Scotland, and enactment of the legislation is anticipated to take place in April 2024. There are 10 Chapters in total being developed (1, 3, 4, 5, 6, 7, 8a, 8b, 9 and 13).

The State Hospital has been identified as an Early Implementer to test out Chapters 5 and 8b of the legislation. Chapter 5 relates to “real time staffing” and risk escalation and Chapter 8b refers to “duty to ensure appropriate staffing”.

The purpose of this paper is to ensure that the Corporate Management Team remains sighted on the requirements of the legislation, detail the role of the Board, and identify specific actions that need to be progressed to ensure readiness for enactment of the legislation.

2 BACKGROUND

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

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

- provide assurance that staffing is appropriate to support high quality care, identify where improvements in quality are required and determine where staffing has impacted on quality of care
- support an open and honest culture where clinical/professional staff are engaged in relevant processes and informed about decisions relating to staffing requirements
- enable further improvements in workforce planning by strengthening and enhancing arrangements already in place to support transparency in staffing and employment practice across Scotland and through the use of, and outputs from, the Common Staffing Method and associated decision making processes
- ensure the clinical voice is heard at all levels by ensuring arrangements are in place to seek and take appropriate clinical advice in making decisions and putting in place arrangements in relation to staffing including: identification of any risks; mitigation of any such risks, so far as possible; notification of decisions and the reasons why and a procedure to record any disagreement with the decision made

3 ASSESSMENT

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

The main purposes of staffing for health and care services is to provide safe and high-quality services and to ensure the best health or care outcomes for service users.

Reporting

The State Hospital's Quarter 4 report was submitted to the Scottish Government in April 2023. A response was received from SG providing reassurance we are working positively towards our preparedness for enactment in April 2024. However further quarterly reports to the Scottish Government have been deferred to:

Quarter 2 - 3rd November 2023 (to include July – September inclusive)
Quarter 3 - 1st March 2023 (to include October – January 2024 inclusive)

This report also gave areas to be considered which have been included in the previously circulated Q1 report submitted in July 2023

This document provides a thorough and detailed RAG analysis of where we currently sit in our preparedness for the proposed enactment date of April 2024. From the document you can see that both the actions for TSH pilot work is currently sitting at Green with the other actions out with our current scope sitting in Amber / Red. It is important to note that this document was prepared based around the current methods of workforce management. With the implementation of eRostering and the change to current workforce management practice, the RAG status of many items within the attached report may change during this transition period.

A short life project team was established and had its first meeting on 17th July 2023 and will report to the Workforce Governance Group with a remit to work through changes to practice, support the test of change, and mitigate risk. A bulletin was shared following the HCSA Project Team providing resource links for staff to access.

Progress to date

The Senior Nurse Workforce Planning is working closely with a Healthcare Staffing Programme (HSP) Advisor to prepare and support the organization meet the requirements set out in the Bill.

A presentation was delivered to the Board's Development Session on 7th September 2023. There is also another engagement event planned with the Scottish Government on 7th November 2023.

A quality improvement approach is being used in preparation for the Health and Care Staffing Legislation and we have identified 3 tests of change which commenced in June 2023.

Self-Assessment

Roll out to the ID service and Mull hub continues to progress with Iona hub having been provided with an overview of the legislation and what this means to them as a team. The sessions generated good discussions with beneficial question and answer session.

A further session took place providing the current format of the reporting structure. A copy of the Quarter 1 Report was shared with the wider clinical team to give them examples of evidence from a nursing perspective. Psychology colleagues have reached out to Greater Glasgow and Clyde and NHS Lanarkshire for examples from a psychology perspective.

The final session for this service will take place on 18 October and include a SWOT analysis to identify where the team feel they are in terms of roll out.

The first engagement session took place in Mull recently which was well received and attended by a number of disciplines. Session 2 and 3 are being scheduled.

Key Milestones

It was highlighted that the Board are looking for assurance that work is progressing to ensure the hospital is ready for implementation date of the HCSA. A GANTT chart has been developed to highlight each stage until March 2024.

It should be noted that feedback from HIS and the Scottish Government is that TSH is progressing well in terms of engagement sessions, including engaging with the multi disciplinary team. It was noted that not many Boards are taking this approach during their information/engagement sessions.

There was also an offer of further stakeholder sessions from the Scottish Government and this has been confirmed as taking place on Tuesday 7th November 2023 at 10am via MS Teams. This date and associated link will be circulated to all Non-Executive Directors and all key stakeholders via a Communications Bulletin. Staff should be asked on what information they would find helpful to enable to Scottish Government to tailor the sessions accordingly.

4 RECOMMENDATION

Board members are invited to note the content and the ongoing work on progress of work to date. Further discussion on reporting progress will be agreed following the development session on 07 November.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	The Act links closely to the overall clinical and staff governance objectives within TSH.
Workforce Implications	As detailed within the Paper
Financial Implications	This is likely to have financial implications however it is difficult to quantify the levels currently.
Route to Board Which groups were involved in contributing to the paper and recommendations.	Corporate Management Team Staff Governance Workforce Governance Group
Risk Assessment (Outline any significant risks and associated mitigation)	All risks are contained within the quarterly returns and also within the updates to CMT and WGG.
Assessment of Impact on Stakeholder Experience	As detailed within Paper
Equality Impact Assessment	
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	N/A
Data Protection Impact Assessment (DPIA) See IG 16.	Tick (✓) One; ✓There are no privacy implications. There are privacy implications, but full DPIA not needed There are privacy implications, full DPIA included

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	26 October 2023
Agenda Reference:	Item No: 17
Sponsoring Director:	Director of Finance and eHealth
Author(s):	Director of Finance and eHealth, eHealth Project Managers
Title of Report:	Patient Digital Inclusion update
Purpose of Report:	For Noting

1 SITUATION

Driven by the SG Health & Care Strategy, which aims to harness the power of digital services and technology within our healthcare services, the State Hospital (TSH) wishes to ensure that all patients are provided with appropriate opportunities with regard to digital technology and devices.

2 BACKGROUND

The State Hospital already recognises the need for staff, patients, and visitors to own and use technology within the Hospital, whilst also providing a safe and secure environment. A framework is provided through the Technology and Electronic Devices within the State Hospital Policy and Procedures. This sets out the detail of technology/devices authorised for use within the Hospital, and any restrictions that may apply to the use of such technology or devices.

Patients within the State Hospital have extremely limited access to digital technology and opportunities. Current areas of digital inclusion are:

- Use of PCs and supervised access to the internet through the Patient Learning Centre.
- Limited online catalogue browsing as part of an 'enhanced' shopping experience.
- Use of technology to assist/augment communication (there is one device in use).
- As a result of COVID, the rapid introduction of video visiting.

Our patients are experiencing a regressive Digital Inclusion experience as technology develops. While they previously had standalone PCs to use on the wards, the advent of the internet and cloud technologies has resulted in a deterioration in patients' digital experience as content and resources moved online and became harder to control from a security perspective than CD-ROMs or packages installed on PCs.

If Digital Exclusion is not tackled, the gap between those with and without digital skills or access to technology will continue to grow, potentially exacerbating mental health inequalities.

More broadly, being digitally capable is an important part of being included in society and is an important part of the care and rehabilitation of our patients as they progress through tiers of secure care within the forensic network. Our patients need to be prepared to re-enter the digital world in which we now live or face social isolation.

Barriers to digital inclusion for our patients include:

- Access to internet and devices. In a high secure environment, not all digital products are suitable for use and there are necessary service constraints to ensure safe and secure service delivery.
- Skills. Our population varies; some will have little or no exposure. For more recent admissions, we risk deskilling these patients.
- Staff capability and capacity. Not all our staff will have the skills to enable digital inclusion, and eHealth / project management capacity will be required to support developments.
- Funding - given competing priorities, this may not be seen as relevant or as a priority in terms of developments.

3 ASSESSMENT AND OUTCOMES

Led by the eHealth Project Managers, an extensive exercise was undertaken in early 2023 – engaging with a broad range of stakeholders both patient and staff, and with other high secure services in the UK – providing a detailed "Options Appraisal" *(attached)* for Digital Inclusion

This noted the desired strategic benefits of the Digital Inclusion Programme being:

- Patients have improved digital skills and feel more digitally confident. Patients should be empowered to use digital tools to manage their health and become active participants in their care.
- Patients will have improved wellbeing and increased connections as a result of digital inclusion work.
- Our workforce will have improved skills and confidence to engage and support our patients to be digitally included. We need to ensure our workforce are suitably skilled to use the technology and are sufficiently flexible to adapt to new ways of working. Embedding such planning for digital, and the changes it would bring, into all workforce planning, professional development/competency frameworks and change programmes will be essential going forward.
- Clinical staff will have more time for direct patient care as patients are empowered to manage their own daily activities.

Further to the issue of this document, and following consultation with CMT, the next planned stage was undertaken on 12th October – being a well-attended workshop engaging with TSH management and staff from all directorates. *(Slides from this session attached)*. This workshop considered in more detail the main preferences for digital devices and their location, and prioritisation of specific digital inclusion tools.

From this 3-hour dedicated session, these results are now being collated in order to prepare an agreed blueprint for implementation – providing a roadmap with timescales and potential costings.

This will then be presented to CMT and Board for approval, from which it is anticipated a business case will require to be prepared in order that SG funding can be considered.

4 RECOMMENDATION

The Board is asked to note the report, and that final programme approval will be requested in due course.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Essential for TSH Digital Strategy
Workforce Implications	Potential staffing demands e.g. programme staffing
Financial Implications	Tbc – dependant on options appraisal
Route to Board Which groups were involved in contributing to the paper and recommendations	eHealth subgroup Hospital options workshop
Risk Assessment (Outline any significant risks and associated mitigation)	Dependant on options appraisal
Assessment of Impact on Stakeholder Experience	Dependant on options appraisal
Equality Impact Assessment	N/A
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do)	N/A
Data Protection Impact Assessment (DPIA) See IG 16	Tick One ☑ There are no privacy implications. ☐ There are privacy implications, but full DPIA not needed ☐ There are privacy implications, full DPIA included

The State Hospital Board for Scotland

Patient Digital Inclusion Options Appraisal

Report prepared by the eHealth Project Management Team

April 2023

Contents

Purpose of Report

This report was commissioned by the Director of Finance and eHealth, and the Head of eHealth to assess the relative merits of alternative models for the delivery of Patient Digital Inclusion. It also provides a view of a potential Patient Digital Inclusion Roadmap for consideration by the Board that will outline the important foundational activity that must be invested in for long-term sustainable transformation.

The report is intended to provide the background needed to consider alternative models of delivery, an analysis of the options and proposals for a Blueprint and Roadmap for Digital inclusion which if adopted would become the focus of Phase 2 (Business Case Development) of a three phase exercise, the third and Final Phase being the implementation of a preferred option if this is proved and accepted by the Board.

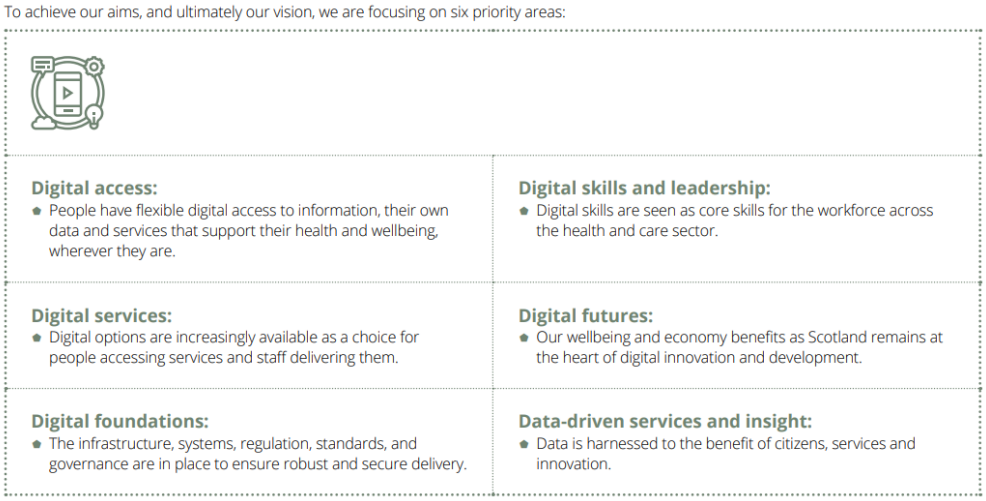
Background – The Strategic Case for Change

This report offers an opportunity to explore the potential, scope, and limitations of Digital Inclusion as it relates to the care of our patients within the State Hospital.

A key driver is the **Digital Health & Care Strategy (Scottish Government and COSLA)** which states:

Our aim is to harness the power of digital services and technology within our healthcare services continues with the publications of Care in the Digital Age: Delivery Plan 2022-23, with a 2023-24 Plan following in April.

To accelerate digital transformation, we will develop our understanding of collective capabilities and capacity in digital services, with Boards expected to participate in a forthcoming Organisational Digital Maturity Exercise to influence medium term planning priorities. Health Boards should continue to ensure resources are available locally to support the delivery of national priorities and programmes, which are detailed within the Medium-Term Plan guidance.



The State Hospital will be held to account, must prepare for several deliverables within these priority areas, and is expected to respond to the Organisational Digital Maturity Exercise starting in April 2023, in which the Head of eHealth is participating.

However, focussing on the Digital Access priority area for the purpose of this report, the Scottish Government's Digital Health and Care Directorate are working on a new programme from March 2023. This will be delivered in partnership with the Scottish Council for Voluntary Organisations and Connecting Scotland and will focus on digital inclusion in Mental Health and Housing. This programme is directed at service users living in the community. It includes this definition and description of the Pillars for Digital Inclusion that informs the development of our Roadmap:

5 Pillars for Digital Inclusion:

Digital Inclusion means ensuring that everyone has the opportunity to develop their skills and confidence and can access an appropriate device and connectivity to do the things they want to do online. As part of our horizon scanning and learning from other work, we have developed 5 'Pillars for Digital Inclusion' which include: motivation, device, connectivity, skills and confidence, and inclusive design.

If Digital Inclusion is enabled through these **5 Pillars,** we must focus on:

1. **Motivation** – how can we best motivate and support our patients to engage. What are the hooks that would attract them to embrace technology e.g. staying in touch with family and friends, entertainment, having more control over their environment?
2. **Devices** – what types of devices are more appropriate for individual needs and settings throughout our patients' journeys?
3. **Connectivity** – what connectivity models are more appropriate to support access to digital resources?
4. **Skills and confidence** – how can we best support our patients to enable them to engage effectively in digital opportunities? An integral part of this is having a digitally competent workforce to work alongside our patients.
5. **Person Centred Inclusive Design** – what are the key, accessible ways to deliver Digital Inclusion to enable our patients to access digital services?

Focusing on the skills and confidence pillar, the UK government had previously published an Essential Digital Skills framework, which lists in simple, relatable terms the digital skills adults need to safely benefit from, meaningfully participate in and contribute to the digital world for life and work (Department for Education, 2018). The five categories of the framework are as follows:

1. Communicating (e.g. communicating with others digitally using email or messaging).
2. Handling information and content (e.g. understanding that not all online information and content is reliable, understanding how to stay safe and behave online).
3. Transacting (e.g. managing an online account to buy goods, complete benefits claims, volunteer/job applications).
4. Problem solving (e.g., use the Internet to find sources of help for a range of activities).
5. Being safe and legal online (e.g. understanding privacy settings and knowing how to behave online).

Other national programme deliverables relevant to our Patient Digital Inclusion ambitions include:

- The expansion of the use of Near Me for group treatment programmes in mental health and educational type interventions
- Access to digital mental health therapies
- The implementation of the Digital Front Door to support access to health and social care services

Naturally, the national programme deliverables are focussed on citizens across Scotland, and we must focus our efforts on the needs of patients in mental health settings, in particular in high secure care.

Our ambitions are particularly informed by the reports '**Supporting Communication & Technology Use in Mental Health Settings (2018 and updated in 2021):** Communications and Technology Short Life Working Group (School of Forensic Mental Health & NHS Scotland Forensic Network).

These two reports provide a detailed literature review, insights into patients' and their carers' experience of digital inclusion and a compelling case for change. Importantly, the reports highlight what is possible referring to the progress made in low/medium secure services in England and make a recommendation to the Scottish Government to form a National IT group to provide a forum to:

- Enable service representatives to stay up to date with new security risks from IT and communication devices
- Consider the application of relevant legislation
- Develop policy and guidance to ensure a consistent approach to technology use
- Influence and support the integration of eHealth within secure services
- Promote consistency and standardisation in the use of hardware/software across the estate
- Link with National initiatives which may provide assistance to services (e.g. Connecting Scotland)
- Define support required for patients to enable them to develop digital skills and knowledge of how to use the internet safely
- Review staff training needs and develop proposals to address these

The Working Group's 2018 report suggested stratified levels of access, which for High Secure were:

- No personal devices
- Access to safe email
- Access to hosted digital service, walled garden, and approved white site list on hospital devices
- Controlled Service access to Video Conference
- Games Console (not WI-FI enabled)

These two reports are with the Scottish Government and await a response, but they form a good foundation for building our own **Roadmap for Digital Inclusion.**

Patient Digital Inclusion Project at The State Hospital 2022-23

The State Hospital already recognises the need for staff, patients, and visitors to own and use technology within the Hospital, whilst also providing a safe and secure environment. A framework is provided through the Technology and Electronic Devices within the State Hospital Policy and Procedures. This sets out the detail of technology/devices authorised for use within the Hospital, and any restrictions that may apply to the use of such technology or devices.

To maintain a safe and secure environment for everyone, The State Hospital's Board has exercised its powers under the National Health Service (Scotland) Act 1978, the Mental Health (Care and Treatment) (Scotland) Act 2003 and the Mental Health (Safety and Security) (Scotland) Regulations 2005 to restrict or prohibit certain items from entry to the Hospital. This includes 'digital' items.

Patients within the State Hospital have extremely limited access to digital technology and opportunities. Current areas of digital inclusion are:

- Use of PCs and supervised access to the internet through the Patient Learning Centre.
- Limited online catalogue browsing as part of an 'enhanced' shopping experience.
- Use of technology to assist/augment communication (there is one device in use).
- As a result of COVID, the rapid introduction of video visiting.

Our patients are experiencing a regressive Digital Inclusion experience as technology develops. While they previously had standalone PCs to use on the wards, the advent of the internet and cloud technologies has resulted in a deterioration in patients' digital experience as content and resources moved online and became harder to control than CD-ROMs or packages installed on PCs.

Technology is fundamental to modern life. The pace at which society is becoming reliant on digital technology is moving fast and it now pervades every aspect of our daily lives. People who are digitally excluded are missing out on the role digital plays in staying connected with friends and family, education, shopping, employability, and accessing online services. Worryingly, there are increasingly fewer alternatives to digitally accessing services, such as banking or essential services such as utilities. If Digital Exclusion is not tackled, the gap between people with and those without digital skills or access to technology will continue to grow, potentially exacerbating mental health inequalities.

More broadly, being digitally capable is an important part of being included in society and is an important part of the care and rehabilitation of our patients as they progress through tiers of secure care within the forensic network. Our patients need to be prepared to re-enter the digital world in which we now live or face social isolation.

Barriers to digital inclusion for our patients include:

- Access to internet and devices. In a high secure environment, not all digital products are suitable for use and there are necessary service constraints to ensure safe and secure service delivery.

- Skills. Our population varies; some will have little or no exposure. For more recent admissions, we risk deskilling these patients.
- Staff capability and capacity. Not all our staff will have the skills to enable digital inclusion, and eHealth capacity will be required to support developments.
- Funding - given competing priorities, this may not be seen as relevant or as a priority in terms of developments.

The State Hospital is arguably in a strong position, due to our population size and contained geography, to be one of the leading services in being able to deliver a truly digital health and care system for our patients. Through collaboration, a focus on a sustainable Roadmap delivered at an achievable pace, and appropriate investment, we could deliver the change required to transform how we deliver services and ultimately improve health and wellbeing outcomes for our patients.

The desired Strategic benefits of the Digital Inclusion Programme are:

- Patients have improved digital skills and feel more digitally confident. Patients should be empowered to use digital tools to manage their health and become active participants in their care.
- Patients will have improved wellbeing and increased connections as a result of digital inclusion work.
- Our workforce will have improved skills and confidence to engage and support our patients to be digitally included. We need to ensure our workforce are suitably skilled to use the technology and are sufficiently flexible to adapt to new ways of working. Embedding such planning for digital, and the changes it would bring, into all workforce planning, professional development/competency frameworks and change programmes will be essential going forward.
- Clinical staff will have more time for direct patient care as patients are empowered to manage their own daily activities.

Summary of work

The Project Management Team was tasked with progressing the Patient Digital Inclusion programme, working with the Digital Inclusion Group and others. Initially the Team was asked to look at Patient Banking and Shopping solutions that would offer a patient facing element and experience. However, it quickly became evident that any system that requires a patient facing element would require being part of a much bigger, wider-scope solution.

It was also clear that any solution proposed should meet our ambitions for a sustainable long-term Roadmap for Digital Inclusion. **The solution chosen must be fit for purpose across our agreed prioritised requirements, and provide a robust, buildable long-term solution to our digital inclusion ambitions for our patients.** It is important to note that the relative strength of one solution for one particular area of content should not unduly influence the decision-making process. There is a balance to be struck.

Key tasks to date include:

- **A requirements analysis** – this was undertaken with around 50 stakeholders consulted to date. A detailed requirements document is available following topic-focussed sessions, which took place between October and January. The conversations were wide ranging and aimed at consensus building but included:
    - Education
    - Patient Banking and Shopping
    - Patient Comms and Messaging
    - Video Visiting
    - Clinical Uses
    - Entertainment
    - Timetabling
    - Menu Ordering
    - Patients' Property
    - Accessibility
    - System Technical Requirements
    - Devices
- **Contact with potential suppliers**, demos, and documentation review to appraise the solutions offered by UniLink and Made Purple who provide systems for secure settings against the detailed requirements obtained from our stakeholder engagement sessions. UniLink and Made Purple were viewed as potential suppliers as this is a specialist market and these systems are in use in other High Secure services - prisons and other special hospital. Other systems demoed and reviewed include Netsupport who provide software to education providers and others, and the Royal Bank of Scotland for alternative patient banking options.
- **Contact with other services:** other High Secure Hospitals (Ashworth and Rampton) and Prison Service (Addiewell)
- **Support for active projects:** Education, Video visits – collaborating with National VC to optimise use of existing system
- **Review of documentation:** Supporting Communication & Technology Use in Mental Health Settings 2019 and 2021 working group reports, previous paper written by Director of Nursing and presented to CGC, DIG (Digital Inclusion Group) group documentation, and Strategy documents as previously listed.
- **Patients have not yet been consulted on these proposals:** The Patient Centred Improvement Team have been involved and the Project Team will attend a Patient Forum to engage patients in this work. It was felt to be important to understand and be able to convey the viable solutions properly and the Project Team will be guided by the Patient Centred Improvement Team to ensure this is done effectively.

Emerging Roadmap

The stakeholder consultations have been incredibly informative and have shaped an emerging picture of what the Roadmap might look like.

While initially we focussed very much on the different modules that solutions offer, it became clear that much of the conversation about what the Roadmap should look like hinges on not only the content, but also the means of delivering that content – the **type and location of devices.** **Table 1** provides a simple graphic to convey how the desired content could be delivered and the impact of the device on how quickly that could be achieved.
In summary:

- **shared devices in communal areas** would enable the delivery of some important content in the short term
- **PC/Device in side rooms** enable the delivery of a full range of content although fair access to the limited shared resource would have to be managed
- **In-room devices** enable all content to be delivered (with appropriate controls in place). This a longer-term option as patient wireless that reaches rooms would need to be installed.

Table 1	**Device & location**			
Content	**Kiosk/shared device in communal areas (ward or hub)**	**PC/device in side rooms**	**Portable devices: laptops/tablets (always supervised)**	**In-room** **(dependent on patient wireless reaching rooms)*
Education	N (but in Education)	Y	Y (devices already being set up)	Y
Patient Banking and Shopping	Y	Y	Y	Y
Patient Comms and Messaging	Y	Y	Y	Y
Video Visiting	N	Y	Y	Y
Clinical Uses	N	Y	Y	Y
Entertainment	N	Y	Y	Y
Timetabling	Y	Y	Y	Y (in Rio currently)
Menu Ordering	Y	Y	Y	Y* *(dependent on Synbiotix)*
Patient Property	Y	Y	Y	
Key:	**Short term**		**Medium term**	**Long term**

**Dependencies:*

- *Patient wireless can be extended to wards to support patient network for devices in **ward/hub** areas, but **in room** is dependent on the installation of a new broader-scoped Hospital wireless system.*
- *The catering service will be implementing a new system called Synbiotix. There is a menu-ordering module, but the interface is for staff, not patients and is not included in the first phase of the project. Future options include Synbiotix developing a patient interface or interfacing another system with the Synbiotix system.*

Summary option appraisal of potential solutions

A detailed Options Appraisal was undertaken taking account of our;

- Functional requirements based on our stakeholder analysis to date
- Qualitative assessment based on the various meetings and topic focus groups
- Financial and pricing models of the solutions available

It should be noted that stakeholders have not been involved in a formal assessment of the options proposed against agreed Design Criteria and this is still an option available to inform the next stage.

Table 2 provides an overview of the suitability of the solutions available. A detailed comparison is provided in the next section of this document.

Table 2	System		Summary
Content	**UniLink**	**Made Purple**	
Education	Need to buy additional system Unify	Y	**Both systems** can add any Apps and Games that we require, with whitelisting of these carried out by the supplier to ensure safe and secure content and patient experience. The learning module from **UniLink** through Unify provides a recording system for patient learning but not specifically the content, which would need to be added by TSH, or an additional system could be purchased e.g. the Moodle eLearning platform. **Made Purple** already have an array of learning content and have developed their own LMS to further expand the system's capabilities.
Patient Banking and Shopping	**Y – had to be adapted for Ashworth but it is expected to be implemented soon.**	**In development – piloting at Rampton**	The **UniLink** system offers a comprehensive patient monies management system that would support the Finance Team in carrying out many of the functions they undertake currently. The internet shopping experience for our patients is similar to what we have in place now, with a catalogue browsing experience of whitelisted sites although the patient then needs to enter the details onto a separate system to place an order rather than a paper purchase form. The UniLink patient shopping application is comprehensive and supports a variety of shopping experiences as well as supporting stock management, reconciliations of patients' cash and links with EPOS systems. The **Made Purple** system is a spending money system designed to work alongside their shopping app. The internet shopping offers a browse, click, and add to basket experience and there are other innovations in their development pipeline that are appealing and would offer patients an experience akin to that in the community. Used alongside the RBS CMS (Client Management System) system, and with the future developments of Purple Wallet and online shopping, Made Purple could meet the requirements of finance, procurement staff and the patients.
Patient Comms and Messaging	**Y**	**Y**	Both systems are similar in functionality with inbuilt AI features to ensure incoming and outgoing post is controlled and secure. Made Purple have the additional security of all content being kept within the Made Purple ecosystem and not going through third party systems. The Purple Post App is also more user friendly and intuitive, offering a better user experience for both patients and their approved contacts, with minimal or no cost to

			the patient. UniLink has inbuilt survey creation tools, where Made Purple would link to externally created surveys.
Video Visiting	**Y**	**Y**	The current Video Conferencing solution we have in place is becoming end of life and is not fit for purpose. Both **UniLink** Virtual Visits and **Made Purple's** Purple Visits are similar in functionality and introduce improved security features, and benefits to staff, patients, family and carers, and professional visitors**. UniLink** has built in disassociation and allergies functionality, and is cheaper per call, but **Purple Visits** is more intuitive and user friendly and can be developed and configured to meet our specific requirements. Made Purple provide the required equipment, whereas equipment for UniLink would need to be sourced from a third-party supplier**.**
Clinical Uses	**Y**	**Y**	**Both UniLink and Made Purple** provide a whitelisting service and can host any apps we approve. The introduction of devices on wards introduces a whole host of possibilities for the delivery of content and information, and capture of data from patients, some of which is currently possible on the Made Purple and UniLink systems, with the ability to add forms, whitelisted websites, applications, and games as required. Potential benefits include improved data collection, reportability, patient wellbeing, digital literacy, collaboration, engagement, clinical efficiency, and a patient experience more in line with general society.
Entertainment	**Need to buy additional system Unify**	**Y**	**Both Made Purple and UniLink** provide similar functionality, though **Made Purple** have a lot more content available, having developed some of their own content themselves. **Made Purple** provide all required equipment, whereas in room DSE equipment would need to be purchased separately for the UniLink solution. **Made Purple** are continuously looking to add additional content and develop new elements of the system. **UniLink** will add additional content upon request and at an additional cost to the customer. A third party, Unify Solutions, provides all entertainment functionality from UniLink.
Timetabling	**Need to buy NForce CMS Scheduling and Apps modules.**	**On Roadmap**	**UniLink** have an existing list view of scheduled activities, which can be viewed by patients and managed by staff. **Made Purple** are designing a calendar solution which will display in a calendar style layout, which both staff and patients can view and manage.
Menu Ordering	**Y**	**On Roadmap**	**UniLink** has a well-established menu ordering system already in place with pictures, colour coding and nutrition symbols, with built in workflows. **Made Purple** have a forms-based system in place currently but are developing their own menu ordering system which will have similar functionality to the UniLink system, with a potential opportunity for being developed to our specific requirements. The Synbiotix system is a comprehensive catering management system that we will be using but will need a patient facing ordering system to link to it.
Patient Property	**Y**	**On Roadmap**	
Accessibility	**Y**	**Y**	**Both systems** are designed to be user friendly and accessible to users of all abilities, with **Made Purple** having added various additional accessibility tools, which are configurable to suit individual patient needs. Kiosk and in-room devices are touch screen with pictures and coloured tiles for ease of use and navigation.
Technical requirements	**Y**	**Y**	Both UniLink and Made Purple solutions meet our System Technical Requirements with slight variation in approach.

Detailed Option Appraisal:

The next section of this document provides detailed narratives of the extent to which the solutions available meet our Patient Digital Inclusion requirements.

We have decided to include these **'stories'** to provide readers of this report with a real sense of the scale of this undertaking, inform them of alternative approaches to achieving our ambition, and convey the complexities of delivering this Digital Inclusion Roadmap.

This is very much a transformational change programme; it is a series of small complex projects in a challenging environment that will take years to deliver.

Education

Access to online learning opportunities, where patients can complete online courses and gain qualifications e.g. ICDL, open University Courses, SQA (Scottish Qualifications Authority) etc. is of high value to patients. Being digitally capable is an important part of being included in society and is an important part of the care and rehabilitation of our patients as they progress through tiers of secure care within the forensic network and mirror the experience in the community where common activities are completed on-line. Examples would include benefits claims, volunteer/job applications, retraining/education. A critical area for our patients will be helping them to understand how to stay safe online.

We have achieved some increased access for patients to modern digital technology through the expansion of the patient learning network and the introduction of new portable devices. Once they have completed testing and are available in the wards, these will enable patients to access their learning materials from these devices, where they are currently restricted to only PCs within the Patient Learning Centre. The devices will help us to deliver integrated/cross-departmental learning programmes and opportunities. Devices on wards will support Digital Inclusion for patients who are not able to access the Skye Centre or hub area.

Providing a walled garden for safe internet browsing and whitelisting as a service:

Patients should be able to safely access whitelisted websites for information and research e.g., Encyclopaedia Britannica, read articles, and research topics for education. Patients need safe access to the internet to be able to engage in digital based learning at each stage of the Employability Pathway and ensure that digital skills are expanded and built upon. Learning to utilise modern technology will improve patient confidence and skills, as well as enhance the patient experience. This requires a 'walled garden' approach - a browsing environment where users are restricted to certain content on a website and allowed to navigate only particular areas of the website. The main purpose of creating a walled garden is to shield users from certain kinds of information and prevent unauthorised access to other links, chatbots, social media etc.

UniLink have an education portal module through Unify, where links can be added to whitelisted sites as required. UniLink's partner company Unify provide Whitelisting as a Service at a cost per site, which allows access to filtered internet (allowed sites).

Made Purple have partnered with Encyclopaedia Britannica to create a modified school app, giving patients the tools to undertake self-motivated learning by allowing learners secure access

to unbiased, fact-based articles, on thousands of topics and categories, providing search engine that will evolve, ensuring each learner has access to up-to-date information at their fingertips. It is updated daily and curated by professional editors. Providing access to Britannica's full range of education resources whilst keeping learners safe online, the app is the secure alternative to web-based search engines and restricts users to viewing approved content only. Secure links to SQA, ICDL can easily be added as required as Made Purple provide whitelisting as a service. Made Purple currently provide a link to Kings International High, an on-line school.

Patient Learning Management system:

The **UniLink** CMS (Client Management System) Education/Assessment module provides effective monitoring of patient achievements, qualifications, and allows the creation of custom assessments with setting targets. This is a record of the patient's learning, not learning content. Qualifications can be assigned, awarded, and tracked throughout the system. Pending qualifications can quickly and easily be monitored and updated. The system integrates with scheduling - assessed individuals with targets set are scheduled onto activities to work towards those targets. Activities can be tied to qualifications and assessments so that success and retention statistics can be produced from the system. A "learner journey" screen provides the ability to quickly review an individual's activity history and progress against their targets.

Made Purple are developing a Learning Management System that would allow us to deliver our own or third-party educational courses both live and on-demand. It is scheduled to be available by the end of April 2023, allowing staff members to upload and deliver remote education to residents, providing progressive additions to the platform.

Access to Whitelisted Games and Apps:

Increased access to apps and games for leisure and entertainment purposes are desirable to support our patients' development of digital and ICT skills helping them to improve their confidence and have an enjoyable digital leisure experience, Whitelisted Games and Apps can be added to **UniLink** through Unify. A wide selection of games is already available including card games, educational maths game, chess, driving games, and others.

Made Purple provide various games for entertainment including Flappy Crow, Connect 4, Tetris, Snake, Shuffle Puzzle Etc – other applications and games can be added as required.

Conclusion

Both systems can add any Apps and Games that we require, with whitelisting of these carried out by the supplier to ensure safe and secure content and patient experience. The learning module from **UniLink** through Unify provides a recording system for patient learning but not specifically the content, which would need to be added by TSH or an additional system could be purchased e.g. the Moodle eLearning platform. **Made Purple** already have an array of learning content and have developed their own LMS to further expand the system's capabilities.

Patient Banking and Shopping

We need a ward based electronic interface so that patients can have more independence in managing their budget - know how much is in their account, the balance available to spend, track expenditure.

The system should also provide a contactless payment system for purchase of vended goods, thus enabling personal financial responsibility and reflecting consumer behaviour outwith TSH. Patients should be able to check their account balance in advance of their physical visit to the shop on the ward. Patients then visit the shop and select items to be rung through the till and charged to their account. This system should be cashless and involve either a card and/or pin number solution that allows the patients to authorise items to be charged to their account.

Patients should be able to view available stock, show alternatives to out-of-stock items and place orders for goods from the shop via a ward-based interface. These items should be charged to the patient's account. Patients should be able to access a range of websites that allow safe browsing and click through ordering that enters an electronic approval and ordering process with visibility of the order progress for the patient.

This will support patient rehabilitation and preparation for modern living with technology by offering an experience more akin to life in the community and help patients gain life skills in in-person and online shopping and online banking.

What we have now:

Department of Work and Pensions pay money into NatWest Gov account and funds are transferred into patient funds RBS account (main holding account). Finance staff allocate this money and any private funds to the patient's individual account in the Trojan banking system, which is essentially a patient 'wallet.' We have recently made the Patients' funds RBS accessible on-line via Bankline enabling faster turnaround of patient transactions, having previously relied on paper statements. RBS have a CMS system for managing clients' money that we are investigating as a potential replacement for Trojan.

Finance provides paper statements to patients. Patient Bank staff inform patients of their balance when withdrawing cash for the shop and the change is redeposited. There is no current digital way for patients to view or manage their accounts/monies.

Patients have one allocated shop day per week and currently go to patients' bank to withdraw cash via cash handler, take the cash to the shop to make their purchases then return any change to patients' bank. Patients' bank staff manually update patients account on Trojan.

For on-line shopping, we have provided a patient catalogue browsing experience with access to 3 whitelisted websites. Once a patient has identified an item, they fill in a paper PPP1 form, which then goes through the appropriate approval process via hospital mail before being delivered to the Procurement Team who will place the order. While this process can be completed in a few days, it can sometimes take 3 weeks and is vulnerable to staff absence as stages in the approval process are tied to individual staff members rather than roles.

Banking system:

The **UniLink** system provides a comprehensive patient banking system. Patients can view their account balance and account summary with a detailed transactions view. The Account Balance ties into the backend Finance module, which records incoming transactions from Patient's pay, incoming funds or savings and outgoing transactions from shopping, Pin Phone Top-up (if in use) or special request payments. Family can also send funds directly to the system via BACS payment.

Approved staff users have access to patients' funds to allow them to view while the Finance and Procurement teams would be able to process transactions. Patients can also move funds and make requests via the system with communications going directly to the Finance Team.

Made Purple's Purple Wallet is a spending money system. Purple wallet lives within the Made Purple eco system and allows staff to add funds directly to a patients account, patients will also have the ability to request funds be added via the Purple Wallet application. It is a spending money system that is designed to work alongside Made Purple's shopping application. Currently patients will only be able to see funds allocated to their Purple Wallet and not all their accounts.

Staff users with the required permissions and patients have visibility of patients' accounts. Staff would move money from a patient's account into the Purple Wallet although it may be possible that a future version of Purple Wallet could link to either Trojan or the RBS system to bypass this request process and allow patients to move their own funds into and out of the purple wallet as required. Patients can view statements showing balance and transactions, or these can be printed by the Finance Team. Patients will be able to see their balance and their account history all within the Purple Wallet application either on their in-room device (tablet) or via the Made Purple OS communal area machines.

Staff members with access can add and remove funds from the Purple Wallet and there are plans to open this up to enable patients' families to send funds to the patient through the App, using a facial verification system to ensure an audit log of people that are sending money into patients is accurate.

Internet and on-site shopping:

In UniLink, patients have read only access to approved whitelisted websites hosted by their partner Unify. Unify offer Whitelisting as a Service if we wish to add to the sites already available.

Once an item is identified on a shopping website, the patient needs to enter the order into the UniLink CMS system in a form format, which goes through an electronic approval process and is then sent on to procurement. Patients and staff can then track the progress of orders. UniLink would investigate and cost the development requirements of a more streamlined process, without having to enter into another system.

Front and back-office support for a variety of shopping experiences: face-to-face, bag-and-tag and/or Self-Service. It is fully integrated with CMS Finance, enabling rapid reconciliation and analysis of sales of goods to patients. It offers controls on spend and sale item restrictions. The system includes stock management and assists with inventory and stock control. It supports cash, cashless or mixed payment types

CMS Retail provides enhanced patient canteen and stock control and integrates with a patient Self-Service Kiosk Canteen functionality. The system supports multi-site sales and distribution from a central warehouse or from local stores. Products can be grouped and sold from product catalogues, thereby providing further control of sale of items.

In addition to normal item sales, the system allows the sale of items that are classified as patient property; purchase of such items is automatically submitted to Property control to approve or deny, therefore streamlining the management of patient property.

Stock item maintenance provides visibility and financial control over the stock ordering and stock management process with user access control prevents staff from authorising transactions above their purchase limit. The system uses advanced automation for stock ordering, thereby reducing the time taken to order and receipt goods. Stock levels and stock value are viewable at a glance.

Once patients have placed their orders on the kiosk, the items are ready to be picked in the warehouse/stores. The system provides a Secure Retail kiosk where patients working in the shop can manage the entire stock picking process from start to finish in a secure manner, thereby increasing patient employment and providing valuable experience that can be used in the real world.

The **Made Purple** system enables patients to securely browse any of the website's products and add items they wish to buy to a list, including details such as size and colour, which is then sent directly to establishment staff for approval and purchasing. The current list of stores includes Amazon, Argos, Asda, M & M Direct, Sports Direct, Big and Tall, Foot Asylum, Get The Label, HMV, Jacamo, JD Sports, Mainline Menswear, Music Direct, Tesco, Nintendo, with additional stores being added including Amazon. TSH would be able to add stores on a per patient basis and for just one session if required. All these stores will have the Purple Wallet integration whilst giving the full shopping and online experience to patients in a secure and controlled way.

Orders can either be delivered digitally to the Procurement Department to order as we do now, or they can automatically have the order placed directly with the retailer once approved for items to be delivered to our stores for distribution. Once Purple Wallet is enabled, patients are only able to order items that they can afford to order at the time with funds from their Purple Wallet. Made Purple would be charged for items ordered and TSH retrospectively billed each month.

The 1st iteration of the Purple Wallet will include a warning message to patients when they are placing orders stating that any unauthorised / banned items (for example such as hoodies) will be held in their property box until the time of their release (wording can be adjusted) which mitigates against patients attempting to order items that they are not allowed to have from vendors that are approved on the shopping network.

The 2nd iteration of the Purple Wallet will include a digitised property tracking solution which will also be able to manage volumetric controls, for example if patients are allowed 2 pairs of trainers and they attempt to order a third, the system will warn them that their new trainers will be held in stores until they hand in an older pair, for example.

The 3rd iteration of Purple Wallet sees the introduction of the NFC Purple Wallet debit card that will enable patients to use the ward shop / canteen with their own debit card and use purpose

built vending machines that will use the card and use facial verification or PIN to ensure the correct patient is using the card. This will also use the volumetric control system to ensure patients are not stocking up on liquids or the like which may enable a prolonged hostage situation etc.

The aspiration for the Purple Wallet system is to provide patents a safe and secure way to manage money just as they will be doing when they are integrated back into society, providing them with the independence of moving money from their savings account to their spending account (Purple Wallet) where they can then be empowered to use onsite shops or vending machines as well as gaining digital experience by shopping online. Patients will be able to see all their transactions using the Purple Wallet app, which will be similar to using a digital bank in society such as Starling or Monzo.

In the future Made Purple hope to create an additional Purple Wallet card that can be used contactless in society for example if a patient needs to attend an outside hospital for the day or if they are spending the afternoon outside of the hospital grounds.

The current version of the Purple Wallet would only allow the patient to purchase items using a Made Purple terminal, but the hospital shop could list their items and receive a notification when an item is ordered through this. For in person visits to the shop, Made Purple could allow for the store to have access to the Purple Wallet account which would let them enter the patient number, (the patient then enters a PIN) and could then ring up physical items. This is not currently available, but the company would work with us to understand our requirement and build this. Made Purple have suggested issuing NFC cards per patient which would work just like a contactless card does, it can be linked to their Purple Wallet, again this is not currently available, but they would be willing to work on this with us.

Conclusion:

The UniLink system offers a comprehensive patient monies management system that would support the Finance Team in carrying out many of the functions they undertake currently.

The internet shopping experience for our patients is similar to what we have in place now, with a catalogue browsing experience of whitelisted sites although the patient then needs to enter the details onto a separate system to place an order rather than a paper purchase form.

The UniLink patient shopping application is comprehensive and supports a variety of shopping experiences as well as supporting stock management, reconciliations of patients' cash and links with EPOS systems.

The Made Purple system is a spending money system designed to work alongside their shopping app. The internet shopping offers a browse, click, and add to basket experience and there are other innovations in their development pipeline that are appealing and would offer patients an experience akin to that in the community. Used alongside the RBS CMS system, and with the future developments of Purple Wallet and online shopping, Made Purple could meet the requirements of Finance and Procurement staff, and our patients.

Patient Communications and Messaging

The Patient Centred Improvement Team advise that patient access to communications is a real priority; this is also stated in the National Working Group's recommendations. Both UniLink and Made Purple provide solutions to facilitate electronic communication between patients and their family, friends, and professional contacts, in a safe and secure way.

Patient Email:

UniLink's Patient Mail service allows friends and family to keep in touch with loved ones whilst they are in hospital by logging on to the Patient Mail site to create and send messages. The service is equivalent to the email a prisoner service available in all prisons in the UK. Messaging displays internal messages from staff (read only notifications) and external messages from approved contacts, with the ability for the patient to respond electronically. Messages are sent to the establishment where they are printed and distributed to residents or, in those establishments with UniLink's self-service system, messages are accessed via kiosks or in room devices. Patients reply to the messages by handwriting a response that is scanned and sent to the recipient or by typing their response on the system. These messages can be sent with attachments (photographs or documents), subject to security screening/checks. The service is free of charge to the establishment. Typically, the sender (patient and contact) pays all fees.

Purple Post allows approved contacts to send full colour digital images and messages to secure establishments using their mobile app, and the patient can send a reply all in a matter of minutes.

Purple Post is delivered directly to the Purple Post Portal where all post and images are vetted by monitoring staff, who then approve or reject the post. Post can then be printed on-site, and hand delivered to the ward/patient or digitally delivered to a Made Purple communal terminal or in-room device for the patient to access when they log onto the device. Contacts can purchase post card credits via the app to use to send post. The patient can send one reply per incoming message free.

Messages are sent via the Purple Post digital system, similar to EMAP (email a prisoner) but the Purple Post system is more secure as it does not use a third party STP or mail server to send emails to the hospital. The platform keeps all messages within the Made Purple ecosystem without the requirement of any additional potential break points.

Visitors register on the Patient Mail Portal (UniLink) or the Purple Post App (Made Purple), providing photographic identification, proof of address and perform a facial scan for facial recognition purposes. Identification is verified by the establishment. A single account is required for the family member/contact to access the Patient Mail Portal, which supports video visiting and sending of mail. Purple Post and Purple Visits are two separate Apps but have the same login details and the contact is only required to register once for access to both systems.

For both systems, all inbound and outgoing messages pass through a secure staff portal with inbuilt technology to scan for key words or phrases, highlighting these to monitoring staff. Key words and phrases can be global for all patients or specific key words and phrases applied to

individual patients. Key words and phrases can be set to exact or partial match. This is a powerful tool to ensure patients mail is monitored with the utmost diligence and efficiency.

Translation:

Purple Post has inbuilt translation, stating which language the post is written in, with the ability to show the translation in English at the click of a button. The sentiment rating shows the percentage of positive, negative, or neutral language used in the post. Mail Monitoring settings are set up for individual patients and specific approvers can be added for individual patients e.g. all post for patient X goes to their RMO for review and approval.

The **UniLink** mail system does not automatically translate patient post, however, the CMS Translate module can be used to translate messages and any other content across the system as required.

Managing contacts:

Contacts can be banned from sending post and the reason for the ban recorded on the system. For Made Purple, contacts can be banned on Purple Post and not on Purple Visits and vice versa and require to be banned separately on each system if required. UniLink ban contacts on the Patient Mail site, stopping contacts accessing both video calls and post, not one or the other.

Notifications and comms:

For **UniLink**, staff can send read only notices or information to patients, via the self-service notifications module. A notice can be sent to all patients, or a selection of patients based on configurable criteria. The system also records when the Notice has been read, providing an audit trail.

Through **Made Purple**, sending individual messages to individual patients and opening a live chat style dialogue is currently available when a patient submits a complaint or form, and through the Purple Wallet shopping function, but this functionality can be built into other areas of the system as required.

Made Purple provide an application called Journey as a patient Intranet, which can be used to send notifications to groups of patients or individuals. Journey can also be used to view notices, read FAQs, log system faults, complete surveys, submit complaints and suggestions, as well as co-authoring of policies, and complete electronic forms e.g. to request a GP or hairdresser appointment.

UniLink has specific modules, accessed through the patient dashboard, for FAQs, Notifications, completion of complaint forms and has built in functionality to create forms and surveys, with an integrated reporting tool, enabling full analysis of survey results. Criteria logic enables surveys to be targeted to specific groups of patients.

Conclusion

Both systems are similar in functionality with inbuilt AI features to ensure incoming and outgoing post is controlled and secure. Made Purple have the additional security of all content being kept within the Made Purple ecosystem and not going through third party systems. The Purple Post

App is also more user friendly and intuitive, offering a better user experience for both patients and their approved contacts, with minimal or no cost to the patient. UniLink has inbuilt survey creation tools, where Made Purple would link to externally created surveys.

Video Visiting

The current system is the National Video Conferencing Service (NVCS) which manages the provision of video conferencing infrastructure across NHS Scotland, hosted by NHS NSS. The infrastructure is end of life in December 2023 and will be de-commissioned and need replaced. A national options appraisal has been circulated and E-Health Leads are informed of the decommissioning timeline and are advised of the options available.

Four options are presented:

Option 1 – Do nothing

Option 2 – Update end-of-life infrastructure to Feb 2025

Option 3 – Decommission all video conferencing infrastructure and devices

Option 4 – Implement cloud-based solution for device registration and bridging

The only viable option to support TSH would be option 4. This option would see all VC infrastructure decommissioned, whilst allowing devices to register with a cloud-based service. This would provide boards who continue to rely on video conferencing devices for hybrid meetings, have purchased newer equipment, or who provide clinical services using devices with a low-cost option to ease the cost and burden of a rapid migration.

This would support point to point calling, access to a cloud based bridging service and would maintain access to Teams meetings till devices were replaced as part of a longer-term upgrade programme.

Devices could remain in use until autumn 2024, allowing the cost of replacement to be spread over a 2-year period and providing time to migrate services.

The impact of all other options would be that VC calls into MS Teams meetings cannot take place. Contact with courts, local authorities etc. will be stopped. Patients will be unable to take part in group sessions hosted on CMS. Family visits for State Hospital patients (hosted on CMS) will cease.

Depending on decisions to be taken about the future of VC, all aspects of Video Conferencing will need to be evaluated by The State Hospital, but this is outwith the scope of the Digital Inclusion Programme.

The cost to replace high use meeting room systems is estimated to be around £211k nationally, however, replacing on-prem infrastructure is judged to be not cost effective or in line with the move towards Teams. An option (£16k) to provide cloud-based registration of devices for a further 12 months is available. This is in line with the EOL date for most of the remaining devices and provides a low-cost mitigation to smooth the transition. NVCS continue to support the transition to Teams or Near Me.

The current VC system is free to use and there are no additional costs per call. Current equipment is sufficient but there have been issues with sound quality due to the secure casing that the equipment sits in. Replacement equipment would be beneficial to improve video visiting experience for patients and their relatives. Many devices are already EOL, or due to be EOL in February 2025.

Limitations of current system:

Patient visits on the current VC system cannot currently be monitored remotely, so nursing staff are present in room when the patient is on a video call to monitor behaviour and ensure conversation is appropriate. Staff members could be added as a participant on the call and join from another device, callers would see that there is another user on the call, with a blank box for the nurse, who would be on mute and camera off. The nurse could terminate the call for all participants if required. There is no facial recognition software within the system to identify unapproved persons from participating in calls, therefor it is the responsibility of the monitoring staff to identify unapproved persons and manually terminate calls if required. There is no indicator visible to the patient/relative showing the time left in the call, only a 10-minute warning, so calls can end abruptly before participants can say their goodbyes, which can be frustrating for patients and their families.

NVCS allows interoperability with other VC systems, but the bridging can be difficult to set up and manage. There has been noted difficulty in sending out required joining links to visitors, with links having been sent via letter if the visitor has not provided an email address. Joining instructions can be lengthy and complicated, and some families require support from Social Work staff with equipment set up and joining video visits, however, the National VC Team can be contacted for support as and when required. The ISDN gateway, which allows telephone participants to join calls via telephone, is now end-of-life. An alternative solution would be required for TSH to allow participants to join via telephone and to facilitate group sessions and multi-site calls.

The system does not have functionality such as blurred backgrounds, raise hand etc which would be helpful for professional visits, CTM's etc. NearMe could be used for professional visits, which does have this functionality.

Near Me:

Near Me is a secure form of video consulting approved for use by the Scottish Government and NHS Scotland.

Near Me is widely used by GP practices and other Health Boards for online patient video consultations and may be useful within The State Hospital for professional visits, however, it is not designed for patient video visiting with family and friends.

Near Me has additional functionality including: a virtual waiting room for patients/visitors to allow controlled joining of consultations/group sessions, blurred backgrounds, chat functionality, raise hand function, screen share, switch/reverse camera function (mobile devices only), consult now function which allows the professional to instantly send a link for the patient/visitor to join bypassing the waiting area.

Near Me is a service that runs on PCs and mobile devices using their browsers. No specialised equipment or downloaded software is required. Staff or callers only need a compatible web

browser, webcam/microphone/speakers, or headset. Near Me cannot be accessed using any of the standard VC units or by telephone.

There is no cost to NHS Scotland boards or users - the service is paid for by the Scottish Government.

UniLink and Made Purple (Purple Visits):

Both UniLink and Purple Visits are designed for secure institutions. Video Visits provides a simple, secure, and cost-effective alternative to visits in person, helping patients to stay in touch with loved ones whilst they are detained. These cloud-based solutions use secure point to point connection between the callers, preventing potential call interception by third parties.

Both systems provide additional layers of security which the current VC system does not provide, including facial recognition, alerting monitoring staff to unapproved persons appearing on screen, including children. The technology is also able to differentiate between an image of a person and a live person. **UniLink** has built in disassociations functionality, which Made Purple are looking to develop in the near future. **Purple Visits** requires the App user to identify themselves using facial recognition to enter the video call. Purple Visits also blocks the ability to screen cast or take screenshots or recordings from the family members device.

Approved contacts are required to register online and provide photographic identification and proof of address, which is then verified by the establishment. Family/Carers can then add the required patient to their App, and book video visits at a time and date that suits them from a list of booking slots available. All sessions are pre-booked and approved so that only authorised visitors can participate in call. Patients can request calls through the App on the kiosk or in room devices for both systems. Booking slots are configurable, staff can approve, reject, and cancel calls as required. Purple Visits has the facility to book intake calls to allow contact with family quickly whilst the registration process is in progress. Visitors can be banned, and notes added on the system e.g. reason for ban. Bans can then be removed as required. Banned visitors will be unable to book visits until this restriction is lifted on the system.

Both systems give selected staff access to live, ongoing calls for security and monitoring purposes. The monitoring officer can listen in to active calls, pause and mute speakers and add notes for colleagues if a call must be terminated. Full control is given to the monitoring officer. The software detects and acts on inappropriate behaviour as well as unauthorised people appearing on screen. Settings can be configured per call to pause or alert the monitoring officer when conditions are breached. Audio and image are frozen for both the patient and their family member until either the monitoring officer manually allows the call to continue or terminates the call. The system can be configured to automatically restart the call once the parameters are met, e.g. unapproved face is removed. Sensitivity of facial recognition can be set per call to avoid unnecessary pausing of calls, e.g. when the face is momentarily obscured due to the family member touching their face or drinking from a cup.

Live video visits are not translated by either system, a translator could be present in room during the visit or at the monitoring station or could be added as an additional participant to the call.

Both systems allow for the recording and playback of visits by the establishment. Recordings can be downloaded as required. Purple Visit recordings are held on the system and automatically deleted 93 days after they have been completed. **UniLink** Video calls are

recorded and retained for 14 days as standard with options to store recordings for longer as required and authorised subject to legal restrictions.

Although it has been agreed that video visits should not take place in patient bedrooms, the technology has the capability to be enabled on any device as and when required, if the device has the required camera and microphone/headset.

Both systems have a fully searchable database showing security related information and statistics on usage, all user data, and previous calls.

For **Purple Visits**, calls are scheduled for specific booking slots, there is a 5-minute countdown timer that is displayed on both the patients and the family members device letting them know how long they have left when the call is nearing the end. You have the choice to set a hard cut off which will terminate the call at the end of the time or allow for a grace period at the end. You can also set up and create on demand video calls using the system which can be set to any length of time.

For **UniLink**, a timer is visible with count down and audible warning at 5 minutes remaining, which is configurable.

Purple Visits has over 200,000 verified users of purple visits from 129 countries around the world and the platform is both intuitive and easy to use for members of the public and patients. Both the Purple Visits and Purple Post apps are very user friendly and simple to set up.

The portal used for booking and managing calls from within the hospital is more intuitive and fit for purpose in a high secure setting when compared to Zoom, Google Hangouts, or Skype with the addition of the proprietary security features.

UniLink Virtual Visits launched in June 2020 across the private and public prison estate in Scotland, over 100,000 calls have been handled to date.

The technology for both systems can facilitate links to external broadcasting services such as a video link to enable patients to attend funerals virtually if they were unable to attend in person. This functionality could also be used to, for example, allow patients to attend Skye Centre church services or events virtually.

The **UniLink** system can also be used for booking in-person patient visits, managing disassociations and highlighting allergies and dietary requirements by associating warnings with patients/visitors. **Made Purple** do not currently have this functionality but are interested in working with us to develop their system to suit our specific requirements.

Costs per call for **UniLink** video visits are less than **Purple Visit** calls, which can be payable by the establishment or the visitor.

Conclusion:

The current Video Conferencing solution we have in place is becoming end of life and is not fit for purpose. Both UniLink Virtual Visits and Made Purple's Purple Visits are similar in functionality and introduce improved security features, and benefits to staff, patients, family and carers, and professional visitors. UniLink has built in disassociation and allergies functionality, and is cheaper per call, but Purple Visits is more intuitive and user friendly and can be

developed and configured to meet our specific requirements. Made Purple provide the required equipment, whereas equipment for UniLink would need to be sourced from a third-party supplier.

Clinical Uses

Many interesting clinical uses for devices were highlighted during the requirements gathering process. The introduction of devices on wards could support sharing of data and other health related content directly with patients and enable patients to participate in clinical data collection. Although UniLink and Made Purple are not designed to be clinical systems, the devices could host some of this type of content as links to whitelisted sites can be added to the devices for patients to access.

Sharing and exploring clinical data with patients:

Staff would like to have tablet or laptop devices available to share and explore clinical data from the Tableau platform (e.g. DASA or BMI), or information from Rio Electronic Patient Record, to provide patients with a visual representation of their own data. As systems like Rio and Tableau are hosted on the staff network, the content would need to be delivered on a staff device, logged on to by a staff member. There is also the potential for screen mirroring (Q-Interactive), where the content on the staff device could be displayed on the patient device in a read only format, without the ability for the patient to access the staff network or systems.

Accessing health and well-being apps and games:

There are many NHS approved apps available which provide self-help material for common conditions such as stress, anxiety, low mood, and sleep problems. There are also games which have a medical/wellbeing benefit. These could be used with staff on a tablet device on the ward with the patient or by the patient in their room. Again, both UniLink and Made Purple can host approved, whitelisted content on their devices. Additional apps and websites can be added as required. An internal app approval process will be required.

Access to health resources and other content:

Being able to share videos or other resources on portable devices to patients to help with the patient journey is considered important. Examples given included condition specific resource examples include Autism Scotland, Diabetes patient information, or showing patients a virtual tour of their discharge location e.g. Rowanbank. Videos can be uploaded for patients to view on both Unlink and Made Purple Systems, with Made Purple having a secure YouTube site available for patients to view approved YouTube videos on the Journey patient intranet system.

Capturing and feeding back data in real-time:

The current process for this is to capture the data for neurocognitive assessments on a paper form, which the clinician manually calculates or takes back to a computer to enter the data into an online form or system, the score is calculated and then fed back to the patient. The ability to capture data and provide instant feedback to the patient could support engagement with patients. Clinicians could access electronic assessment forms e.g. CORE via a website, which the patient would have a log in for, allowing the data to be captured electronically, automatically calculating scores.

Patient alerts:

The ability to set alerts to encourage completion of assessments/activity by patients e.g. a reminder to do homework, stretch/do exercises etc. was also requested. This functionality could be built into both systems through the messaging/notifications; however, the patient would need to be logged into a kiosk or in room device to receive the notification, or by way of a wearable device which is not currently provided by either system.

Wearables and medical devices: Health and wellbeing monitoring through use of smart devices such as activity trackers, normalising use of trackers now extensively used by the general population. There are concerns about consent from patients to wear the devices and if the devices/apps are classed as medical devices/providing medical 'advice' based on data collected. UniLink and Made Purple do not currently provide a solution to this requirement.

Conclusion

The introduction of devices on wards introduces a whole host of possibilities for the delivery of content and information, and capture of data from patients, some of which is currently possible on the Made Purple and UniLink systems, with the ability to add forms, whitelisted websites, applications, and games as required. Potential benefits include improved data collection, reportability, patient wellbeing, digital literacy, collaboration, engagement, clinical efficiency, and a patient experience more in line with general society.

Entertainment

Patients should be able to access entertainment systems within their bedrooms. Currently most patients have a TV in their bedroom, which they have purchased themselves. Some patients have an Xbox to play games on, CDs, CD Players, DVDs, and DVD players. Due to the advancement of technology, it is becoming increasingly difficult to purchase TVs that are not ‘smart’ TVs with the ability to access the internet. The need to provide a hosted service on TSH controlled devices is becoming more pressing.

Having a standard, hospital issued, hosted, and controlled device within patients' bedrooms would provide additional security and would remove the need for multiple devices and discs, while improving their quality of life, ensuring equality between patients, as they will all have the same equipment and access to the same resources. A single solution could also save patients money, as they would not need to purchase their own devices, CDs, DVDs, and video games etc. For patients to keep their Xbox and be able to continue playing Xbox specific games, the in-room devices would require an HDMI connection, which may come at an additional cost, but other gaming options are available. There would also be a reduction in storage requirements for patients’ property. The proposed solutions would also ensure equality for patients where English is not their first language, and better accessibility for patients with literacy, hearing, or visual impairment etc.

Operating systems and devices:

Made Purple can supply in-room devices, or the Purple Operating System can be installed on our own devices if required. UniLink only provide the set top box with keyboard and mouse, which attaches to the back of a monitor or TV, which would need to be supplied by TSH. The set top box has the Unify PICS software installed on it.

Content available and control:

Both UniLink (through their Unify system) and **Made Purple** systems provide a wide range of entertainment functionality for patients, from access to games, TV and Movies, Newspapers and Magazines, to Radio and Music, and eBooks. All content is whitelisted and approved for use by the supplier.

Made Purple are looking to have a content partner on-board by mid 2023 to offer premium on demand TV and movies, that will be similar to Netflix or Amazon prime with a subscription-based funding model, this will complement the current on demand TV stations currently available.

UniLink, provided by their partner Unify, have individual Apps on the patient dashboard for each category of entertainment, with a selection of games, radio stations, newspapers and magazines, TV stations and movies, all with age ratings and restrictions being configurable. All channels and accessible media are controlled by the secure facility, meaning no unauthorised channels or films can be accessed. The system has been developed to ensure unsuitable content cannot be accessed, and user hours can be controlled as required.

Made Purple provide digital Radio, live in the UK and Australia, with various stations available, which are customisable, and patients can add 'favourites.' The Purple MDM radio gives access to hundreds of pre-approved digital radio stations with the facility to restrict stations, including BBC sounds which is an on-demand radio show player with podcasts, and the recently introduced 'Purple Tunes' Application.

Various games are already included in both systems, but additional games can be added as required, which will require being whitelisted by the supplier at an additional cost.

Both systems provide access to a library of eBooks, with Made Purple having over 66,000 pre-approved eBooks available to read via the Purple MDM solution.

Audio books are not currently available on either system but **both UniLink and Made Purple** are looking to procure audio books soon, with Made Purple hoping to have all eBooks available as audio books in the coming months and are working with Audible to offer a restricted library of audio books. There would be additional costs from both UniLink and Made Purple for audio book content.

Both systems provide wellbeing, mindfulness, and relaxation apps, with Made Purple having developed their own meditation tool, which offers unaided and guided meditation content.

TSH would not be restricted to only the content currently available within the systems provided by the supplier. Additional Apps, games, books, movies, educational resources, links to external sites etc. can be requested and would be whitelisted by the supplier, before being tested by TSH staff to ensure suitability for release onto the live system for patients to access. All content is customisable to TSH requirements. There are additional costs for Whitelisting as a Service, however, if another establishment were to request content and pay for the whitelisting, this may then be available for all other organisations to use free of charge.

UniLink provide patients with access to specific approved news and magazine sites. With **Made Purple**, patients can search through 7.5k magazines, all updated monthly, in a variety of languages. The Purple News Stand Provides over 3000 newspapers and magazines in 14

different languages digitally via the Purple MDM solution. Specific newspapers/magazines can be blocked for all patients or specific patients, or can be blocked for a set time for e.g. when there is an article in the newspaper that the clinical team would prefer the patient(s) not to see etc.

For **UniLink,** the CMS Kiosk contains all the patient facing self-service functionalities, enabling the desired configuration to be displayed on all or specific self-service devices, i.e. choice of displayed modules on a per patient basis. Individual groups can be created within our environment for **Made Purple**, to allow access to apps on a per patient or group of patients basis. Once logged in, the patient only sees applications that are applicable to them, with every account set up individually, where you can add patients into required permission groups, or allocate permissions individually per patient.

Language, translation, and accessibility:

The patient interface is available in over 20 languages for **both systems**, where the patient selects their language of choice upon login. Some content is available in various languages within UniLink, with the addition of CMS Translate to assist staff in the translation of any required content by exporting the content into CMS Translate then importing the translated version back into the system, with the ability to add additional languages at a cost per language.

Made Purple also provide some translated content. Content such as news, magazines and radio stations are available in various languages, however, content added by TSH would not automatically be translated. The family/carer interfaces/apps are available in over 20 languages to help family members through the registration and call request process etc.

Both systems have read aloud functionality, where any content within the system can be read aloud to the patient. This would be disabled within communal areas, unless a headset was available, to reduce the risk of confidential information being heard by others within proximity to communal devices.

Conclusion:

Both Made Purple and UniLink provide similar functionality, though **Made Purple** have a lot more content available, having developed some of their own content themselves. **Made Purple** provide all required equipment, whereas in room DSE equipment would need to be purchased separately for the UniLink solution. **Made Purple** are continuously looking to add additional content and develop new elements of the system. **UniLink** will add additional content upon request and at an additional cost to the customer. A third party, Unify Solutions, provides all entertainment functionality from UniLink.

Timetabling

Currently within TSH, timetabling is managed via the Rio EPR system, for Skye Centre activities, 1:1 and group therapy sessions, Occupational Therapy and Psychological Therapies sessions and various other activities. Activities are entered by staff, ahead of planned activities and retrospectively. There is no patient interface for timetables so printed copies are issued to patients, which can quickly go out of date.

A digital self-service system for patients to be able to view and manage their own timetables would be advantageous. Patients would like to know what activities or sessions are available and be able to view an up to date and accurate timetable of their planned activities instead of relying on paper print outs. Access to patient timetables would also be useful for staff to be able to check a patient's availability.

A patient's timetable could also include any GP or dentist appointments, hairdresser appointments, planned outings, tribunal hearings, court dates or scheduled video visits etc, to enable patients to manage their own time.

Within the **UniLink** NForce CMS Scheduling and Apps modules, Timetable displays the Patients planned activities for up to two weeks in advance. It encourages patients to be responsible for managing their own time, reducing the demand on staff. The timetable is displayed in a list format, accessible through any kiosk or in room device. Patients can request GP appointments etc through electronic forms on the system.

Made Purple are developing and are planning to roll out their Purple Calendar app later this year. It will work more like a calendar app, will allow staff to add in events or activities, allow patients to add in their own activities or events like birthdays of loved ones etc, it should also automatically update for video call appointments and physical visits as well as the LMS for dates to hand in homework tasks etc.

Conclusion
UniLink have an existing list view of scheduled activities, which can be viewed by patients and managed by staff. **Made Purple** are designing a bespoke calendar solution which will display in a calendar style layout, which both staff and patients can view and manage.

Menu Ordering

A National Catering Information System, Synbiotix, is being introduced to TSH later in the year, this is for staff use and does not have a patient interface at present, although a tablet ordering option intended to be used by nursing staff on wards is an option. Any additional menu ordering system would need to be able to feed into Synbiotix. **Both Made Purple and UniLink** systems should be compatible with Synbiotix, with configuration required.

Electronic meal ordering would provide great benefits for both patients and staff. This would improve the patient experience, provide accuracy in ordering of meals, be more efficient for staff, freeing up staff time completing paper forms, populating spreadsheets, and emailing the catering department. Accurate ordering would also reduce food waste, saving money. There would be improvements in meeting nutritional standards, portion control and management, meeting allergen legislation requirements and providing dietitians and patients with insights into dietary intake.

The **UniLink** Menu Ordering module enables patients to pre-order their meals from menus displayed clearly on screen and can include pictures if required. Meals can also be assigned health and nutrition symbols, i.e. 5-a-day, as well as special dietary markings. The system identifies patients on any special diets and informs catering staff. Patient menu choices are immediately transmitted to catering staff, removing the requirement for nursing staff to collate paper-based selections. Used with self-service function, allows automated reporting on patient food selection, enabling kitchen staff to determine the meal requirements quickly and easily for

each day, significantly reducing food wastage. Menu items can be selected for up to two weeks in advance, with the ability to edit orders up to a configurable set number of days.

For **Made Purple**, meal ordering can currently be done via the forms within the Journey Patient Intranet, but this is basic for now. A comprehensive menu ordering system is currently being developed by Made Purple and is on their roadmap for completion in Summer/Autumn 2023. This may provide TSH with the opportunity for this module to be developed to our specific requirements. This will include electronic meal ordering where patients are offered menus that factor in cultural/ religious or allergy/intolerance, with the ability for patients to provide feedback on meals and to provide calorific information per patient. Staff will be able to identify if patients have not submitted an order so assistance/intervention can be offered.

Conclusion:

UniLink has a well-established menu ordering system already in place with pictures, colour coding and nutrition symbols, with built in workflows. **Made Purple** have a forms-based system in place currently but are developing their own menu ordering system which will have similar functionality to the UniLink system, with a potential opportunity for being developed to our specific requirements.

The Synbiotix system is a comprehensive catering management system that we will be using but will need a patient facing ordering system to link to it.

Patient Property

UniLink has a module for Patients Property, which is managed through CMS reception, where staff would update the patient's property lists. The patient can view a list of their property items, filtering by items in their possession or items held in storage.

Made Purple do not currently have patient property as part of their system; however, they are keen to work with us to understand our requirements to develop a suitable solution. This would link in with the patient shopping/Purple Wallet module, where items purchased by the patient would automatically be added to their property lists.

Accessibility

When introducing innovative technology to patients, consideration needs to be given to ensure equality for all. Having systems designed with accessibility in mind ensure all patients have access to the same resources in a way that meets their specific needs. Accessible systems improve patient wellbeing, confidence, and motivation, improving their autonomy and independence, and enhances patient recovery, while mitigating health inequalities.

Language and translation:

On login to both UniLink and Made Purple systems, the patient can select their preferred language from over 20 languages. Core content if then displayed for the patient in their preferred language.

Communication between patients and their approved contacts is not automatically translated for **UniLink,** however, their CMS Translate allows staff to display self-service kiosk data items

translated into multiple languages, for example, meal menu items, canteen items, timetabled activities etc. Staff can export the existing English items for translation and then import translated items. Purple Post has an inbuilt translation AI, which automatically translates any content posted between patients and their family and friends. The **Purple Post** and Purple Visits Apps are also available in multiple languages to assist family and friends with the registration, call request process etc. Most of the content available on Made Purple is viewable in multiple languages. Any content added by TSH would need to be translated by ourselves.

Video calls cannot be translated electronically currently; however, an interpreter could be present at the staff monitoring station, in room with the patient or be added as a participant to the call if required.

Accessibility tools:

Made Purple have applied various accessibility tools to the Journey patient Intranet application which includes the ability to increase or decrease the saturation, increase or decrease the contrast, enable high dark/light contrast, monochrome, invert colours, screen reader, mute sounds, stop any animations, highlight focus, change all of the text (size and colour), emphasise titles, adjust text alignment, adjust letter spacing, adjust word spacing and adjust line height. Made Purple have developed their system with accessibility in mind, using colour coding and graphics to make the system simple and easy to use for all abilities. Continued commitment to compliance in accessibility standards ensures a quality learning experience for all abilities. The read aloud tool enables content from all areas of the app to be accessed by all levels of developing reader. The yellow highlight is also supportive of learners with specific dyslexia needs.

For **UniLink**, there are picture attachments when it comes to options on the canteen and kitchen menu for dyslexia etc. and there is an option for audio for the in-room devices. System content is accessed through icons on coloured tiles, which are user friendly and simple to follow. Navigation through the system can be done by recognition of shapes and colours rather than reading e.g. red circle, green square then blue triangle.

Read aloud functionality is available for all system content on both systems, although this would be disabled for communal area devices unless a headset was available.

Conclusion:

Both systems are designed to be user friendly and accessible to users of all abilities, with Made Purple having added various additional accessibility tools, which are configurable to suit individual patient needs. Kiosk and in-room devices are touch screen with pictures and coloured tiles for ease of use and navigation.

Technical Requirements

Whitelisting:

To the ensure the safety of patient website browsing, each site requires to be Whitelisted. Whitelisting is a cybersecurity strategy that only allows an approved list of applications, programs, websites, IP addresses, email addresses, or IP domains, to run in a protected computer or network. Users can only access applications or take actions with explicit

approval by the administrator. Anything outside of the list is denied access. Each individual application or website would be scrutinised, removing any links to other site, chatbots, contacts pages, social media links, advertisements etc, which can be a complex and time-consuming task.

Having Whitelisting As A Service (WaaS) is essential. TSH does not have the staff resources to whitelist numerous sites and applications on an ongoing basis. **Both UniLink and Made Purple** provide Whitelisting as a Service, though the pricing models are different. **UniLink** charge for WaaS on a per patient per month basis irrespective of the number of applications or sites requiring to be whitelisted, whereas **Made Purple** charge a flat rate per website and if another organisation has already paid for the whitelisting of a particular app/site then TSH get access to it free of charge. **Made Purple** also have a target turnaround of around three days to whitelist an App/site. **UniLink** targets are longer. TSH would review and customise any whitelisted Apps/sites prior to their introduction to our environment.

It is a requirement to be able to add our own content, links etc (e.g. can link to patient intranet, can add our own apps and games, websites, education materials, forms, surveys etc) and are not restricted to what content is supplied by the supplier/ already available on the system. **Both UniLink and Made Purple** allow for customisable content. **Made Purple** can link to internal websites as well as external internet sites, as long as the user/patient had access permissions to that location. **UniLink** can link to internal sites, and we can add our own games, apps, education content and surveys etc. through Unify, though we would need Unify to add them to the platform for us as we cannot do this ourselves.

Monitoring and controlling activity:

Both UniLink and Made Purple systems allow TSH to monitor and audit patient activity e.g. websites accessed, key words searched for etc. The **Purple MDM** – Security Control Panel lists devices, device owners, blocked items, audits of searches made by patients, sites accessed etc. It can search and filter by word, app etc. It delivers alerts for device activity or key word search. The Purple MDM comes with an establishment portal, which allows staff to monitor device usage, check history, trends and reset or lock devices. In addition to the Purple MDM, Made Purple also offers a secure operating system for PCs, packed with the same pre-approved content that is customisable and provides analytical data on usage. **UniLink's** CMS Reports system provides a comprehensive report-writing tool where users create their own reports by setting the desired criteria/parameters, i.e. selecting the data fields that they want to appear on the report, specifying the sort order and selecting the report criteria. The system has a fully searchable database with an integrated report-writing tool enabling intelligence gathering on patients and visitors.

Patient login and authentication:

To reduce the number of usernames and password etc that patients need to remember, it was suggested that the login details would be the same as the patients current Patient Learning Network account. One of the key features of **UniLink** is the biometric fingerprint system that is widely used by other organisations that have UniLink in place. This provides a secure access and egress system for patients, staff, and visitors, as well as being used by the residents to access the kiosks and in room devices etc. This reduces the requirement for patients to remember passwords, PIN numbers etc, and reduces the risk of patients sharing passwords or ID cards with other patients. Biometrics is not essential to the use of UniLink systems, other methods of identification can be used e.g. ID cards, PIN numbers and username and

passwords as required. **Made Purple** requires a unique patient identifier, which could be the PLN username or the patient's hospital number, along with a password or PIN. They also have future development plans for facial recognition e.g. for patients to purchase items from vending machines in communal areas, though facial recognition could be used to access all kiosk or in room devices with a camera enabled if required.

Integration with other systems:

Both systems can integrate with other system such as Rio, Synbiotix etc. Made Purple features a fully documented API that any system can integrate with. The Made Purple development team can integrate with any other services that we need, through external APIs and webhooks.

Software patches and new releases:

For **UniLink**, software patches and new software releases, including any new modules, are included in the support and maintenance costs. **Made Purple** software releases are controlled by the MDM control panel and can be scheduled to happen out of hours to avoid any downtime for the patients. All software updates are over the air. Made Purple would provide us with the latest application release into a testing group within our environment, we would then test this before applying the app to our live in use groups. Made Purple pricing is for the platform, which Made Purple are continually improving and working on, premium applications can be applied as required, however Made Purple will never release anything that requires us to pay any extra that will impact the current delivery of the service.

Both UniLink and Made Purple provide device maintenance windows, to block automatic updates which could impact user experience.

Support and Service Levels:

UniLink provide 24/7/365 hardware and software support services according to the agreed Enterprise Support Agreement (ESA) Support Components. **Made Purple** Live Support is available at the touch of a button seven days a week, as well as through the website and Made Purple's social media channels.

For all software support calls to **UniLink**, the initial response from a Software Expert will be within 2 hours (1 hour for High severity calls). Support call logging is available 24/7 x 365 days per year. All incidents are recorded on the UniLink automated support system. When a client contacts UniLink's service desk they are given the call reference number. UniLink will then attempt to resolve the incident. If an incident cannot be resolved or is found to be caused by 3rd Party supplied components, the incident will be reassigned to the client. If it becomes apparent during the investigation of an incident that the Priority Level of a call appears incorrect, UniLink will discuss the matter with the client and agree a new Priority Level, as necessary. UniLink support includes unlimited number of calls to the support line, including assistance over the phone; UniLink supplied Hardware and software support and maintenance, including for e.g. turnstile support where applicable; Free call out visits where/when required, with swap out components to fix faults; Free Annual Audit; User group membership; and Escrow Agreement.

Made Purple will provide a response within 24 hours for all inquiries, within 2 hours (between the hours of 8am and 8pm GMT) for support marked urgent. However, we will also have access to a dedicated account manager that we can contact for any emergencies that will have the

ability to react immediately. We are also able to call our account manager at any time who will be on hand to help with anything that we might need. TSH will have access to a ticket support system within the control panel that staff can use to report any issues within the system itself, these are then smart routed to the best person to assist at Made Purple. Annual pen testing is carried out as standard and Made Purple also have frequent automated tests monitoring the system perimeter.

Hardware swap-out:

UniLink provide hardware 'swap-out' maintenance of all equipment supplied by UniLink as part of the CMS deployment, excluding deliberate damage of any hardware or kiosks. Made Purple will swap-out/replace devices as required and we can have spare devices in stock for instant replacement.

Security:

The **Purple MDM** ensures residents can securely and privately maintain family contact using Purple Visits and Purple Post, listen to the radio, read books and magazines, watch on demand television, play games, practise mindfulness and physical exercise as well as engage in digital education, without the risk of accessing the open internet. The UniLink kiosks will use the existing PatEd Network (Patient Learning Network) and the existing internet security controls for patient whitelisted site internet access.

Both systems provide security vulnerability detection, with Made Purple using the Secris cyber security platform, which provides automated vulnerability scanning to test and monitor our infrastructure, servers, and websites. Made Purple systems continually monitor and protect against external threats, and by cataloguing our current systems we are alerted as soon as any new vulnerability is detected.

Backup and restore:

The **UniLink** system will require its own instance on our existing storage and back-up solutions. A cloud hosted option is also available at an additional cost.

All the **Made Purple** systems have both on-site and offsite backups. They can restore our database to any minute within the last 6 months and have archived hourly backups beyond that. Their ISO27001 certification means they have a full disaster recovery policy, which is regularly tested. Made Purple's ArkDNS (Domain Name System) is a cloud-based DNS service that can filter domains and traffic based on category, automatically detect malicious websites and bots and force users to use SafeSearch on Google, Bing, and YouTube. We can also block automatic system updates on Android, iOS, and Windows devices if we need to reserve our bandwidth. The DNS service must be bullet-proof and scalable. Made Purple use a global Anycast Network with regional load-balancers and auto-scaling groups of servers which can scale to handle up to a billion requests per minute. The service is not tied to any one specific data centre so if there are any issues with connectivity in a region, the user would be re-routed automatically to their next closest server. Made Purple have categories disabled such as violence, gambling, and adult content, ensuring staff are not exposed to anything not safe for work, and disabling the 'Advertising' category means we can browse the web without all the annoying adverts imbedded into websites. For an added layer of security, Made Purple offers Purple OS, an optional operating system for PC machines, which enables you to securely monitor and manage the computers which access the app. Device connectivity can be managed

and configured via the Purple MDM control panel, this includes device certificate-based security as well as a host of other authentication methods. It was created to meet the demands of the global correctional facility and secure hospital estate, delivering the granular level controls required by an authority, which will allow them to be comfortable with a wide-scale rollout of in-room devices that are connected to the internet.

Cloud versus on premise and eHealth impact:

The right solution for the Hospital's patient digital inclusion aspirations needs to meet some key infrastructure requirements. A system located on the cloud would reduce the local overheads needed to maintain the system. On-premise systems would need additional local resources to manage and maintain. These costs would need to be factored in as part of the overall cost of an on-premise system.

Both systems looked at have their merits. They do have different impacts on how they are delivered and supported and in turn supported by the eHealth infrastructure team.

Made Purple offer a cloud-based solution that would remove the dependency on support by the eHealth Infrastructure team. It has no requirement for onsite servers as they are all managed and maintained by Made Purple in their cloud environment. They would provide all the support needed and would also be responsible for ensuring it is maintained to meet their ISO accreditation standard. As the cost for system maintenance is included in the solution there would be no need for additional staffing to manage the Made Purple system.

Both systems would need Infrastructure involvement to deploy and swap out any devices in wards and rooms and this would require additional staffing for the Infrastructure Team as they could not effectively support this requirement.
The UniLink systems as proposed would be hosted on site and would require additional costs to deliver over and above the initial purchase price. These costs would be for virtual servers on our storage platform for the UniLink system, Microsoft server licensing would be required for the servers as would the need to be added to our backup solution. This requirement would need to be managed and maintained by the eHealth Infrastructure team. The UniLink servers for the system would also need to be upgraded as required by this team to ensure compliance with NIS and cyber security concerns. If the system needed upgraded this would also need the support of the infrastructure team and would need to be factored into their work schedule. Currently the infrastructure team have little scope to take on the support of a system of this size and scale. To ensure the availability of the system would require additional infrastructure staff at both senior infrastructure and Infrastructure levels. This should also be factored into the costs of this solution.

UniLink also offer a Cloud option but this would cost considerably more than the on-premise system.

Devices:

Both UniLink and Made Purple devices can be wall mounted or free-standing kiosk style devices, housed within a single secure box, bolted down and secure for use in a high secure setting. Both solutions can be installed on PC or touch screen devices and can be wi-fi enabled or hard wired as required.

Both solutions can 'onboard' devices (wired & wireless) with our NAC (Network Access Control) solution (ClearPass) with UniLink being through secure MAC addresses. Made Purple on board devices via the Purple MDM solution that uses both the android management API and the Samsung Knox API to easily enrol and manage all devices within the system. All in One PCs/devices are sent out fully configured and maintained by Made Purple under a lease agreement or if we would like to use our own hardware, Made Purple can supply a digital ISO for us to flash our operating system onto any off the shelf machine.

Both solutions are compatible with Net Support Software, an additional software solution commonly used in schools, for live monitoring of devices in use, to view patient's application and website usage in real time, with built in key word/phrase monitoring. NetSupport also provides audit logs for reporting and all data is searchable. Staff resources would be required to monitor patient device usage with the NetSupport software in real time.

Both suppliers are ISO 9001 and ISO 27001 accredited, and the data is stored in the UK.

Conclusion:

Both UniLink and Made Purple solutions meet our System Technical Requirements with slight variation in approach.

Devices Session

During the consultation sessions it became evident that there were different viewpoints on what kind of devices were desirable from a clinical perspective and acceptable in terms of security. A separate session was held to focus on addressing some of those quite reasonable tensions and constraints.

Patient Access Authentication – fingerprint or other biometric authentication was desirable as a more secure, less shareable option. The Information Governance and Security Lead advised that to proceed with Biometrics, we would need to meet the legal basis for this. If we can achieve the same with a less intrusive manner, then the law will not allow Biometrics. A separate piece of work is being undertaken by the IG Lead and Security to form a position on this. Clinical colleagues were keen that the system reflects practice in the outside as far as possible and considers that pin numbers or cards might achieve this better, although it was accepted that patients may struggle to remembering their usernames and passwords/PINS.

Kiosks/Devices - Security colleagues were keen on wall mounted, flush and robust kiosks. However, clinical colleagues suggested that if we are trying to move to a more digitally inclusive environment, then standing at a wall to browse does not replicate the outside world. It is also important to consider the physical disabilities of patients, and the aging population of patients, not all would be able to access a wall mounted kiosk. Handheld devices, in a brightly coloured secure case, geo tagged would be preferred. If a patient were to break a tablet, then the patient's risk management would need to be altered. Security reiterated a concern about devices being used as a weapon. We will need to look at testing the technology, generally tablets are difficult to break and would need to go through our hospital testing to see how it can be broken, and how the screens shatter etc.

Processes/operating procedures – as processes are not fail safe, we need to ensure that the risks are controlled. eHealth advised that they are looking at replacing the corporate Wi-Fi first, which can then be extended to reach patient areas for patient Wi-Fi in room. Devices will be tracked and there will be security in place to ensure that a patient cannot join corporate wireless. Reassurances were acceptable around the walled garden nature of these systems, with a set menu, allowing particular apps etc would be fine for in room. Security were more nervous of email/text, and this would require live monitoring.

NetSupport – additional tools such as NetSupport which allows live monitoring of activity and is used widely in schools was supported. Whilst it is an excellent tool, it requires somebody to take ownership within Security of Patient Learning Centre which could be very resource intensive. It was suggested the patients be able to 'freestyle' within the PLC where NetSupport can be used, and have locked down devices elsewhere, which would not require NetSupport. We can lockdown devices as much or as little as required. From a technical point, we are not concerned that we will not be able to provide a secure service.

App Approval - An app approval and device approval process will be required so there can be a definite path to introduce apps and devices. The PLC have a version that can be adapted.

Video Visiting, Messaging and Calls –security are concerned with the possibility of email, and the increase in the amount of mail received with this. The volume of actual physical mail is quite low, but they can see that email will allow for a substantial increase, which will use staffing resources. It was agreed that Video Visiting should remain within the side rooms of wards, and a device should be installed within the Family Centre for Video Visiting. Video Visiting should not be available within patient bedrooms at this stage.

Lessons from Other High Secure Services

Rampton

Rampton are working with Made Purple and are enthusiastic about their working relationship and collaboration on their development pathway. They implemented Purple Visits quickly in response to COVID and have now introduced Purple Post messaging, the Journey patient intranet (access to policies, news, FAQs, more than 20 websites including NICE guidelines, shopping sites, specialist health support, ICO, complaints, surveys, fault reporting) and are about to pilot a shopping experience for patients. They are also working on a patient property project. The programme has been rolling out for over a year now and they anticipate a further 3-4 years of implementation.

They have 2 devices per ward currently and patients are allowed maximum 30 minutes slots to ensure fair access. They plan to have 4 devices per ward soon. 2 computers per ward, which are timetabled for patient access.

They have had positive feedback from family and friends using the app.

Their Business Case is focussed on empowering patients and reducing pressure on nursing staff. Security band 3s monitor Purple Post and the process is assisted by the

keyword/sentiment tracking capability. Rampton currently pay for all Video Visiting and Purple Post costs.

Ashworth/Merseycare

Ashworth had a head start with UniLink which they have had in place for 4 years, though Rampton have taken the lead with Made Purple and have made lots of progress. Ashworth progress has slowed partly due to Covid but they highlighted staffing resources as a major issue. The lack of a dedicated team to roll out UniLink and address the lack of clinical staff engagement has been a major barrier although they are now gaining some momentum.

They reported that the UniLink requires a lot of configuration to make it suitable for NHS sites, but reported that their experience of working with UniLink was positive.

There has only been one incidence of a device being damaged but this was accidental. There was no additional risk, as the glass did not fall out or smash. The patients are generally careful with the devices as they see the benefit of having them and did not like when the device was unavailable for a few weeks.

The Medium Secure unit use UniLink very differently to High Secure. Their medium secure units have devices in all bedrooms, with off the shelf smart TV's, wireless headset, and keyboard, with a micro PC box attached to the back of the TV on a bracket. They were able to keep costs down by not using UniLink supplied equipment.

Phone calls are via VOIP – only used in Medium secure currently but it's free to use by patients/family as it is over the internet. They get up to 15 approved contact numbers, which are controlled and maintained by Social Work. All calls are unsupervised as it's not in high secure. No calls are allowed to take place between 12-7am to maintain a sense of normality. All calls are free and are auditable, and they can pull reports on usage, ensure use is appropriate etc. International calls are permitted but chargeable, costs are covered by the establishment so as not to disadvantage patients whose relatives live abroad. If it were rolled out to High secure, calls would all be recorded.

A 40 bed Low Secure Unit being opened soon will have in-room devices.

Ashworth looking at introducing menu ordering soon and have done a lot of work to configure the menu ordering system. Dieticians particularly like that they can pull data from the shop and menu ordering to be able to discuss with patients their food consumption etc.

They will be replacing the patient shop in their High Secure Unit soon, to incorporate the CMS for patient cash and finances. Again, a lot of work has been done to configure the banking system.
Most patients love UniLink. Patients provide suggestions for development, e.g. they asked for complaints to be online. ID Patients – some are comfortable with the use of technology, but have posed a different challenge, e.g. some do not have the capacity to use the systems. They can require assistance from staff, and as devices are in patient bedrooms in lower secure services 2 staff are required, which can cause delays due to staff resource etc. Having devices in communal areas would help with this as only one staff member would be required, or other patients might be able to assist. Patients are not allowed in each other's bedrooms.

They use SOPHOS UTM, with a 3rd party CHESS (CHESS is a partner company of SOPHOS), to block specific areas of websites. They do all their own whitelisting. Whitelisting is done by security, so not putting the onus on IT staff. They were unaware that UniLink now offer Whitelisting as a service (but this is a fairly new service from UniLink).

Each patient is individually risk assessed and if they are seen to be using a website inappropriately then that website is removed from their individual access. They do not routinely restrict access to clothing, underwear etc as patients may want to purchase items for their relatives, partners etc. and some patients may want to wear feminine clothing and they do not want to restrict this. They do restrict access to some aspects, e.g. climbing gear on Sports Direct.

UniLink have been responsive, and any development requests have been met, particularly if the development would be of benefit to other UniLink customers.

Ashworth have an Operational Support Manager, who takes responsibility for creating all patient accounts and another member of staff responsible for staff accounts. It has been challenging to have clinical colleagues engage and to adapt to new ways of working.

They use fingerprint biometrics in high secure, with a PIN as a secondary identifier option. This is to reduce bullying and is more secure for high secure patients. Their Medium secure service uses PIN numbers as they are not using UniLink's equipment, and it is difficult to install the fingerprint readers on these devices without any ligature risks etc. The aim is to use biometrics on all devices in the future if this can be done safely. They felt that Biometrics are better for ID patients.

They are looking to install kiosk devices in seclusion rooms to allow seclusion patients to be able to watch TV, make phone calls etc.

They do not use the Video Visiting element of UniLink yet. They started using Teams for patient video calls due to the pandemic but have not got round to replacing this yet but are looking to roll out the UniLink virtual visits across medium secure. Currently all Teams calls are observed.

They do have EMAP (Email a Patient) but this is not really used much as patients do not have the ability to view these electronically on their devices yet. Currently all EMAP messages are received by the mail room, are printed, and delivered to the wards along with general physical post. They are looking at introducing the EMAP onto devices in High secure so patients can view mail on screens in their bedrooms and be able to communicate with MDT e.g. contact their psychologist etc.

Addiewell

Addiewell have a mature full UniLink system implemented over 14 years (timetabling, video visiting, email a prisoner, shopping, canteen, entertainment, banking) with the Unify add on, including Fingerprint access and egress for residents, staff, and visitors. They have kiosks in the halls, in-rooms devices including robust wall mounted devices in high dependency cells. Video visiting takes place on terminal in the visiting halls. Their Prisoner Learning Network is still separate although they were considering adding Moodle to Unify. They have a dedicated UniLink member of staff and prisoners act as UniLink champions for other prisoners.

Broadmoor

We are waiting for clarification on their position.

Financial Assessment and Implications

Detailed costings have been provided by both companies but are commercial in confidence and will not be disclosed in full in this document.

Funding models should also be considered as traditional funding streams may not be suitable. UniLink is likely to be Capital investment as we would be buying their system within TSH. This would have a significant implementation charge upfront with little capability of incremental scaling to meet our requirements. Made Purple have a revenue model when services can be purchased as required. This flexibility will allow up and downscaling of the service as needed but we might need to look at how this could be funded. The challenges and cost implications of cloud versus on-premise hosting detailed in the technical section must be considered carefully.

The results of the high-level financial comparison of the solutions are as follows:

Made Purple

Products included:	**Optional items at additional cost:**
• Mobile Device Management Control Panel • Purple Post • Purple Visits • Purple Wallet • In Room Devices • Kiosks (Communal Areas) • Video Visiting Device in Side Room/FC • PLC Laptops /Tablets/PCs • Noticeboard/ Patient Intranet • Noticeboard/ Patient Intranet on Kiosks • Noticeboard/ Patient Intranet on In Room Devices • Learning Management System (LMS) • Hardware - All in One Devices	• Paying for Video Calls (could be paid by patient/family) • Paying for Purple Post (could be paid by patient/family) • Patient Intranet Fully Managed Content • Website Whitelisting • Britannica

Made Purple	Option	Monthly	Annual Cost	Reduce in room devices from 130 - 120	In room devices with HDMI connection to allow patients to continue using their Xbox 360s
Option 1:	All Products in all areas including in-room devices, hardware included	£17,701.88	**£212,422.56**	**£201,630.20**	130 patients = £251,422.56 per year 120 patients = £237,630.20
Option 2:	All Products in all areas including in-room devices, hardware **not** included	£12,843.50	**£154,122.00**	**£146,928.44**	N/A
Option 3:	All Products in Communal Areas only, including Purple Post	£7,563.18	**£90,758.16**	**N/A**	N/A
Option 4:	All Products in Communal Areas only without Purple Post	£7,268.18	**£87,218.16**	**N/A**	N/A
Option 5:	Purple Visits only	£1,919.86	**£23,038.32**	**N/A**	N/A

UniLink (Does not include costs per video call or message)					
For 130 Patients	**Option**	**Implementation/First Year**	**Monthly Cost (recurring)**	**Annual Cost (recurring)**	**Cloud Hosted**
Option 1:	All Products in all areas including in-room set top boxes, in-room DSE included (purchased from separate supplier at approx. £16,900)	**£259,396**	£6,678.66	**£80,144**	£287,392 (Imp/first year) £108,140 (annual recurring) £9012 (Monthly recurring)
Option 2:	All Products in all areas including in-room set top boxes, in-room DSE Not included (would use current TVs in bedrooms)	**£242,496**	£6,678.66	**£80,144**	£270,492 (Imp/first year) £108,140 (annual recurring) £9012 (Monthly recurring)
Option 3:	All Products in Communal Areas only, including Patient Mail & Virtual Visits (does not include VV equipment)	**£220,222**	£6,465	**£77,570**	£248,218 (Imp/first year) £105,566 (annual recurring) £8798 (Monthly recurring)
Option 4:	All Products in Communal Areas only without Patient Mail & Virtual Visits	**£209,778**	£6,465	**£77,570**	£248,218 (Imp/first year) £105,566 (annual recurring) £8798 (Monthly recurring)
Option 5:	All Products in all areas without Biometrics or camera/badge printer	**£237,964** (further discount expected on Kiosks as they will not require fingerprint reader, and potentially reduced annual support fees)	£6,455	**£77,464**	£267,812 (Imp/first year) £105,460 (annual recurring) £8788 (Monthly recurring)

A Blueprint for Patient Digital Inclusion and a Roadmap for Implementation.

This document has provided a detailed summary of what it is **possible** to achieve for Patient Digital Inclusion. However, it is essential that we reach consensus on establishing a Blueprint of what is **achievable, affordable, and deliverable.** As well as an analysis of system functionality and cost, this must include an analysis of the **pace** at which TSH can take on this programme and the resources required to support it. This will be a transformational change programme with many individual projects (with crossover). The scale of the programme means that it will involve most parts of the service at some point in the journey.

Patients Digital Services Team

There are resource implications throughout the implementation of such an ambitious transformation programme from project management, the management of the system and devices, the monitoring aspects of any of the solution used, redesign of workflows, content management, managing security, and the upskilling of staff and patients will have to be taken into consideration in the recommendations. Based on the lessons from other High Secure Services it is likely that dedicated teams (Project and BAU) will be required to take this forward comprising of the following roles, some of which will be new posts:

Role	Project	BAU
Programme Manager	✓	
Project Manager	✓	
Project Administrator	✓	
Procurement Lead	✓	
eHealth Technical Lead – other roles dependent on whether hosted in cloud or on-premise	✓	✓
System Administrator	✓	✓
Clinical Lead(s) - nursing and others	✓	✓
Patient & Carer representatives	✓	✓
Patient Intranet Content Administrator	✓	✓
Security Lead	✓	✓
Comms monitoring staff	✓	✓
Estates Lead	✓	✓
Business Change Lead	✓	✓
Learning and development lead - Patients	✓	✓
Learning and Development Lead - staff	✓	✓
Other subject matter experts depending on module being implemented: e.g. Finance, Catering.	✓	✓

Potential Roadmap and Timescales

Suggested Phased Implementation of Chosen Digital Inclusion Solution with Estimated Pricing					
	Based on Clinical Model of 120 patients across 10 wards				
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**
Devices	Communal area devices in all Wards 1 x wall mounted device per ward (10) 1 x PC in Side Room per ward (10) 1 x floor mounted kiosk in Skye Centre (1) Software installed on PLC PC's, Laptops and Tablets (approx 20)	Introduction of communal area devices in the Hub areas 1 x Floor mounted device per Hub (4) 1 x additional floor mounted kiosk in Skye Centre (1) Install system on remaining patient accessible Skye Activity Centre devices (approx 5)	Introduction of additional functionality e.g. Menu Ordering, patient property and Timetabling on all existing communal area devices	In Room Devices in all patient bedrooms in the treatment and recovery, and transition wards 72 x in room devices	In Room Devices in all patient bedrooms in the treatment and recovery, and transition wards 48 x in room devices
Content	PLC and wall/floor mounted devices: All educational content, patient banking and shopping elements, patient intranet, Noticeboard, FAQs, Surveys, games, communications and messaging, timetabling. Side room PC's: all of the above plus video visiting	PLC/SC and wall/floor mounted devices: All educational content, patient banking and shopping elements, patient intranet, Noticeboard, FAQs, Surveys, games, communications and messaging Side room PC's: all of the above plus video visiting	All existing content plus new additional content appropriate for communal area devices	Everything that is available on the communal area devices as well as all entertainment elements including TV, radio, magazines, newspapers, music, ebooks, audiobooks etc. Note: no video visiting to take place in patient bedrooms.	Everything that is available on the communal area devices as well as all entertainment elements including TV, radio, magazines, newspapers, music, ebooks, audiobooks etc. Note: no video visiting to take place in patient bedrooms.
Calculation	10 x wall mounted devices 10 x PC's with software instaled 1 x Floor mounted Kiosk Implementation costs Costs per module/application	Ongoing exisiting costs 5 x additional floor mounted kiosks Software costs for additional device install	Ongoing exisiting costs Additional costs per module/application	Ongoing exisiting costs 72 x in room devices Additional module/application costs	Ongoing exisiting costs 48 x in room devices Additional module/application costs
UniLink	**£157,111.93** (plus an additional £27,996 if cloud hosted)	**£59,837.65** (plus an additional £27,996 if cloud hosted)	**£39,886** (plus an additional £27,996 if cloud hosted)	**£87,605.20** (plus an additional £27,996 if cloud hosted)	**£84,224.80** (plus an additional £27,996 if cloud hosted)
Made Purple	**£83,805.48**	**£91,364.76**	**£98,444.76**	**£165,828.12**	**£210,750.36**
UniLink Total over 5 years	**£568,645.58** **Based on Cloud Hosted Model**				
Made PurpleTotal over 5 years	**£650,193.48**				
	Note: It would not be possible to role out any solution to only 2 out of the 4 hubs initially, as this would require similar solution running in paralel with each other e.g. Video Visiting along with the existing Video Conferencing solution. It would also not be fair on the patients who would not be able to access the solution in the PLC and on the Skye Centre devices.	**Pricing for UniLink based on 120 patients where the cost would not change dependant of which elements were used.** **Made Purple pricing is variable depending on number of patients, number of devices in use, number of modules in use etc. Pay as you go model.**			
	Note: Made Purple pricing does not include whitelisting per site as would be based on number of sites requested.				
	Note: cost of video calls and messaging per call/message not included in pricing				
	Note: UniLink pricing includes assumption that in-room hardware can be purchased from a separate supplier for £140.85 per patient/room.				

The very different pricing models used by Unilink and Made Purple make it difficult to make direct comparisons. Unilink have significant upfront costs and then the system and content is available to up to 120 patients. Made Purple pricing would be tailored according to actual usage (per device, per patient), and can therefore be introduced more incrementally. We have provided an all services/all patients breakdown for the sake of comparison. These costs are indicative based on costs supplied by the suppliers during the requirements gathering process. They will have to be refreshed as we enter into a formal procurement process and have clarity about the modules we wish to have in place.

It is also important to note that the content that is described as being deliverable would still have to be configured. Some of it could be available quickly, but other systems will require a significant amount of work to be ready for use.

However, this is intended to provide an indicative Roadmap of what could be achieved over a 5-year period.

Recommendation

This Options Appraisal process has detailed the State Hospital's Patient Digital Inclusion requirements and provided an analysis of the extent to which the solutions available can help us to realise our ambitions. It is important at this stage to get the ownership of Senior Stakeholders and the Patient and Carers who will use the system to agree a Blueprint for the future vision for Digital Inclusion.

It should be noted that stakeholders have not been involved in a formal assessment of the options proposed against agreed Design Criteria and this is an option available to inform the next stage. At the very minimum, it is recommended that an event or events be held to extend stakeholder involvement to reach consensus on a Blueprint for Patient Digital Inclusion at the State Hospital and the Roadmap to deliver this vision.

Extending stakeholder involvement:

- Consultation session with CMT (Corporate Management Team) and other stakeholders. A 3-hour, dedicated session to agree the preferred Blueprint – we have suggested what is possible but Based on this Options Appraisal it is recommended that the Board proceed to develop a business case for the development.
- Consultation sessions with patients and their carers/visitors. The Project Team look forward to engaging and will be guided by the Person-Centred Improvement Team on the best approach.

Once the Blueprint and Roadmap are agreed, a formal business case will need to be prepared and signed off by the Board and funding options identified. This would form Phase 2 of this programme.

Patient Digital Inclusion: a digitally enabled transformation

Building a Vision and Roadmap

Housekeeping

Welcome

- Fire Alarms
- PAA
- Comfort breaks
- Tea and Coffee facilities

Ways of working

- Respect the opinions of others
- Allow others to have their say
- Breakout groups need to come to a decision through consensus or majority vote, with one final vote per group
- Questions at the end of the workshop

Agenda

Time	Agenda Item
9.10am	Housekeeping and Agenda
9.15am	Introduction: Overview and outputs
9.20am	Scenarios
9.30am	Context, Lessons Learned, Dependencies and Pressures, Benefits and Risks
9.40am	Focus on Devices
9.50am	Device - Speakers
10.00am	Breakout Session 1
10.20am	Comfort Break
10.25am	Results from Breakout Session 1
10.30am	Focus on Content
10.50am	Content - Speakers
11.00am	Breakout Session 2
11.15am	Comfort Break
11.25am	Results from Breakout Session 2
11.30am	Resource Requirements
11.45am	Pricing Models, Funding and Procurement
11.50am	Finance and Procurement Speakers
11.55am	Vision and Roadmap, Next Steps
12.10am	Questions and Feedback

Overview

- Outcome: Consensus on our Vision and a Roadmap to deliver it
- Moving from what is **possible?**
- To what is **achievable and deliverable?**
- **Readiness: understanding the magnitude of the programme and the resources needed to make it happen.**

What is possible?

The possibilities have been detailed in the report. Today's focus will be on:

- the extent to which devices and content are rolled out.
- the order in which devices and content are rolled out.

What is deliverable?

- Affordability: Financing, SG, procurement routes, business case.
- Capacity within existing services
- Additional resources required

Readiness for transformational change

- Programme management
- Leadership, clinical engagement and governance
- Change Management approach
- Benefits management and measurement
- Resources for change

Scenarios

Future Patient Experience

Daniel - is cared for as an inpatient in high secure services - it is 2028 and Daniel;

•Has independence and ownership of his day-to-day life, this is enabled through his access to technology whilst the service continues to mitigate and manage risk, meeting national and local security requirements. For example, Daniel can use the touch screen in his bedroom to choose his meals, order items from websites in a secure way, communicate with his care team and manage his hospital cash accounts.

•Can communicate with his friends and family, he can call his Mum from the privacy of his bedroom when he wants to, all calls can still be monitored as required to comply with security directions. This helps him to feel independent and confident in progressing along his journey to recovery. He is still "connected" when he is in his room.

•Can do his coursework on a PC in the peace of his bedroom or in the Ward Side Room, learning new online skills as he does which he knows will help him when he is well enough to be able to return to college in the community. This encourages him to engage with the patient education team and leave the ward, he has a regular weekday routine that helps him sleep better and feel better.

•He is benefitting from enhanced security, keeping him safe in a non-intrusive way. Using everyday technology in innovative ways to minimise his perception of restrictions and maximise his ‘free’ time and independence whilst working within security frameworks, for example being able to manage his own timetable, do mindfulness and relaxation sessions, request an appointment with the hairdresser, or shop online for a birthday gift for a family member.

Scenarios

Future Staff Experience

Sandra - has worked with in high secure services as a nurse since 2012. It is 2028 and Sandra;

•Works within a “paper light” service giving her more time to care for patients rather than handling paperwork. The senior management team are enabled to make informed strategic and operational decisions using the additional intelligence sources and Big Data now available through their accessible dashboards, all fed from the improved electronic data the clinical and security systems collect with minimal effort as paper has been minimised. Delivering care patient side.

•Is able to access assessment forms at point of contact with a patient from anywhere using agile, secure, ruggedized kit, minimising her ‘office’ time, reducing time and effort to complete routine tasks and empowering her to spend the majority of her time providing care and minimise time spent on administrative tasks.

•Supports the use of technology because she knows that her and her colleagues suffer reduced numbers of violent incidents, minimal staff sickness and feel motivated and supported to work with minimal frustrations as technology is simple and accessible to them.

Context

- **Lessons learned** from TSH DI projects and other High Secure Services
- **Dependencies/pressures** – wireless infrastructure, Synbiotix, National VC system

Lessons Learned from other High Secure Facilities and TSH Projects

- Clarity of Roles and Responsibilities and ensuring that adequate resources are allocated
- Staff engagement is crucial
- User buy-in is imperative to success

Lessons Learned

Lessons Learned from Other High Secure Facilities

Roles, Responsibilities & Resources

- Dedicated DI Staff Members
- Rampton have Security band 3s who monitor Digital Post and the process is assisted by the keyword/sentiment tracking capability
- Rampton have 2 devices per ward currently and patients are allowed maximum 30 minutes slots to ensure fair access
- Ashworth progress has slowed partly due to Covid but they highlighted staffing resources as a major issue
- The lack of a dedicated team to roll out UniLink and address the lack of clinical staff engagement has been a major barrier although they are now gaining some momentum at Ashworth
- Ashworth have an Operational Support Manager, who takes responsibility for creating all patient accounts and another member of staff responsible for staff accounts
- UniLink requires a lot of configuration to make it suitable for NHS sites
- Ashworth were able to keep costs down by not using UniLink supplied equipment

User Buy In

- Prisoners act as DI Champions to Assist new Prisoners at Addiewell
- The patients are generally careful with the devices as they see the benefit of having them and did not like when a device was unavailable for a few weeks due to accidental damage

Staff Engagement

- It has been challenging to have clinical colleagues engage and to adapt to new ways of working

Operational

- International calls are permitted but chargeable, costs are covered by the establishment so as not to disadvantage patients whose relatives live abroad
- Each patient is individually risk assessed and if they are seen to be using a website inappropriately then that website is removed from their individual access
- Ashworth felt that Biometrics are better for ID patients
- ID Patients – some are comfortable with the use of technology, but have posed a different challenge, e.g. some do not have the capacity to use the systems.
- Access is restricted to some aspects, e.g. climbing gear on Sports Direct
- Rampton currently pay for all video visiting and digital post costs

Dependencies and pressures

Dependencies on other systems:

- Synbiotix
- RBS client management system (maybe)
- EFinancials
- Trojan

Infrastructure:

- Wireless network replacement
- No wi-fi in patient bedroom areas currently
- SWAN or alternative network to host patient services

Pressures:

- National VC system option appraisal and replacement
- Unavailability of non-SMART TVs
- Patients losing digital skills as technology changes
- Patients losing access to resources that were previously available in disc format e.g. Encyclopaedia Brittanica

Content is Dependent on Device Location

- Shared devices in communal areas would enable the delivery of some important content in the short term
- PC/Device in side rooms enable the delivery of a full range of content although fair access to the limited shared resource would have to be managed
- In-room devices enable all content to be delivered (with appropriate controls in place). This a longer-term option as patient wireless that reaches rooms would need to be installed.

Table 1	Device & location			
Content	**Kiosk/shared device in communal areas (ward or hub)**	**PC/device in side rooms**	**Portable devices: laptops/tablets (always supervised)**	**In-room** **(dependent on patient wireless reaching rooms)*
Education	N (but in Education)	Y	Y (devices already being set up)	Y
Patient Banking and Shopping	Y	Y	Y	Y
Patient Comms and Messaging	Y	Y	Y	Y
Video Visiting	N	Y	Y	Y
Clinical Uses	N	Y	Y	Y
Entertainment	N	Y	Y	Y
Timetabling	Y	Y	Y	Y (in Rio currently)
Menu Ordering	Y	Y	Y	Y* *(dependent on Synbiotix)*
Patient Property	Y	Y	Y	
Key:	**Short term**		**Medium term**	**Long term**

Benefits and Risks

Details of all Risks and Benefits were included within the Pre-Workshop Reading Materials.

The majority of Risks associated with implementation of a Digital Inclusion Solution can be mitigated through system security features and other measures

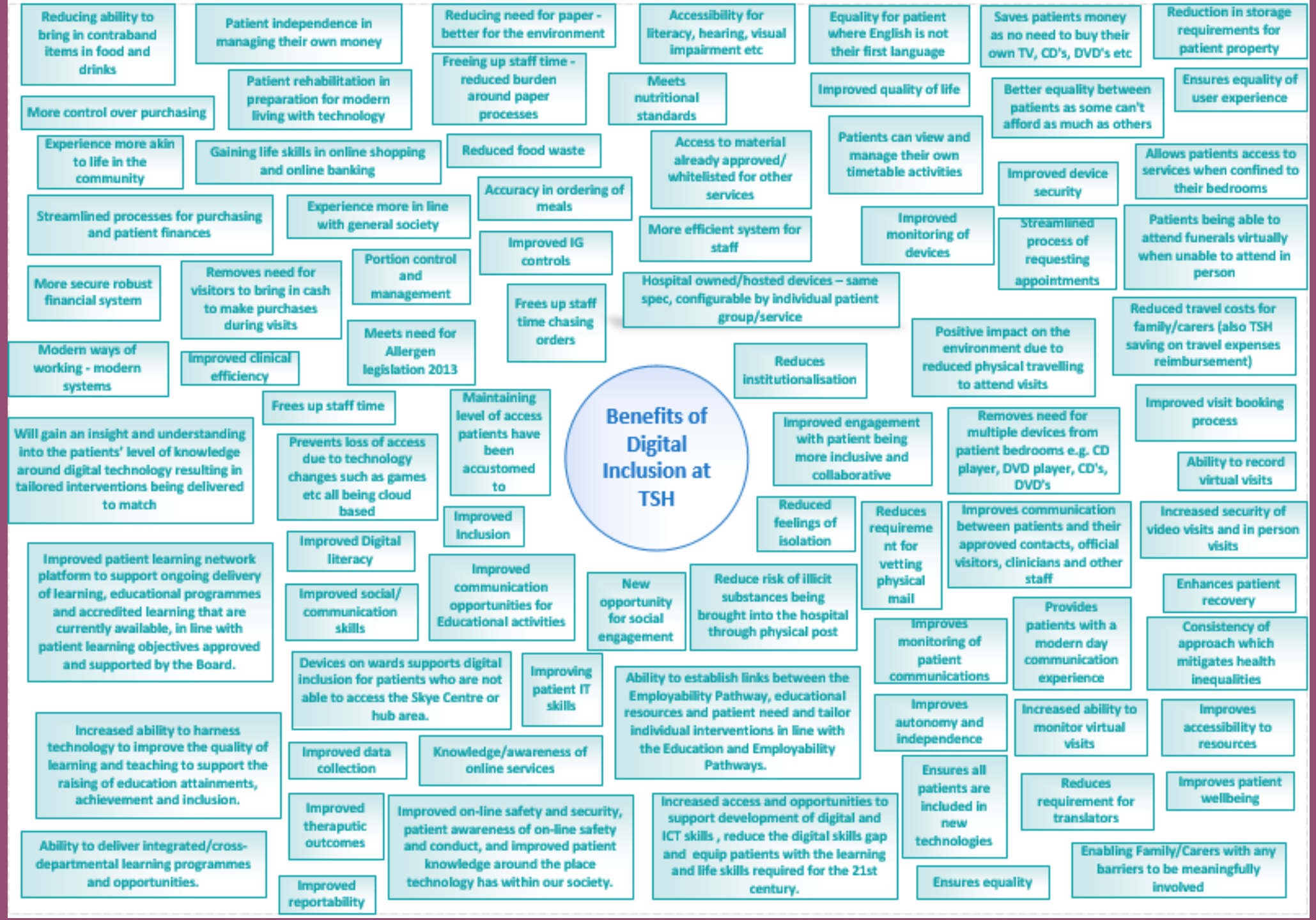
Risks and Benefits

Risks – Do Nothing

- Exclusion from access to Online Digital Services
- Lack of Motivation to learn and engage
- Our patients need to be prepared to re-enter the digital world in which we now live or face social isolation
- Lack of Digital Confidence
- Loss of access to games the patients used to be able to play due to everything now being cloud based
- Patients not having the skills to survive in a modern world
- Lack of consistency and standardisation in the use of hardware/software across the estate
- Difficulty for relatives/ carers who may not be IT Literate and find the joining process confusing/complicated
- Patients who move on from High Secure having never used a touch screen device
- Patients not having the IT skills to navigate the Internet Safely and Securely
- Patients having limited understanding of Online Security
- Risk of patients not having the same experience/access to content as others
- Patients unable to engage effectively in digital opportunities
- Finance still relying on paper bank statements
- Our population varies; some will have little or no exposure. For more recent admissions, we risk deskilling these patients
- Risk of unauthorised visitors or children appearing on screen during Video Visits
- Patients not being able to fill out online application forms to apply for benefits or a job in the community
- Patients are experiencing a regressive Digital Inclusion experience as technology develops
- Lack of Equity between Patients
- Less Secure systems and devices for patients
- Some patients may not be able to afford to purchase their own TV, DVD Player, CD's, DVD's, Games, Xbox etc
- Devices that are not Hospital owned/ hosted –Varying specification, not configurable by individual patient group/service
- Restrictions in Social Interaction and Communication with Family, Friends and Legal Contacts
- Patients unable to attend the Skye Centre missing out on Education Opportunities
- Patients continue to have multiple devices and media within their bedrooms
- Delays in patient purchasing due to paper approval process
- Digital Health & Care Strategy (Scottish Government and COSLA) requirements not being met
- The gap between people with and those without digital skills or access to technology will continue to grow, potentially exacerbating mental health inequalities
- Staff spending excessive amount of time completing paper based processes and admin tasks

Risks and Benefits

Risks and Benefits



Focus on devices

Devices

Floor Mounted Kiosk Style Device

Wall Mounted Kiosk Style Device

In Room Device

PC

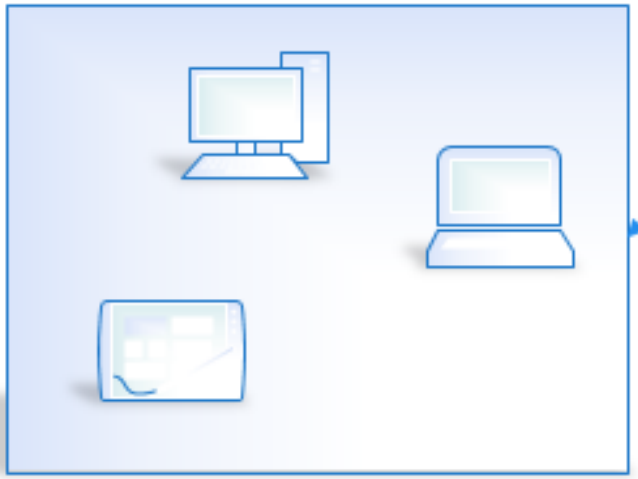
Tablet

Skye Centre

Content

- Education
- Shopping and Banking
- Menu Ordering
- Timetabling
- Noticeboard
- FAQs
- Patient Intranet
- Requests
- Surveys

Patient Learning Centre



Software Installed on existing PC's, Laptops and Tablet Devices within the Patients Learning Network

Atrium

Floor Mounted Kiosks in the Skye Centre Atrium

Shop

Linked to Shop till – funds deducted from patients account electronically

Hubs

Hub – Floor or Wall Mounted Device in each Hub

Content

- Check Account Balance
- Menu Ordering
- Request GP Appointment
- Shopping
- Noticeboard
- FAQs
- Surveys
- Timetable

Ward – Floor or Wall Mounted Device in each Ward Communal Area

Ward Side Room – PC with Video Visiting Equipment

Above content plus:

- TV, Movies, Radio, News, Games
- Mindfullness & Relaxation
- Course Work
- Research
- Message MDT, Family, legal contact

In-Room – Display Screen Equipment with keyboard and Mouse

Family Centre

Video Visiting Equipment in the Family Centre to facilitate Hybrid Virtual and In-Person Visits

Staff Devices

Monitoring Officers

Specified staff will be required to monitor patient communications and video visits. Tasks include:

- Approving or rejecting contact requests
- Authenticating contacts identification
- Reviewing all patient incoming and outgoing digital post
- Setting up mail monitoring permissions
- Setting up keywords and phrases per patient or globally
- Viewing, monitoring, pausing and terminating video visits
- Intelligence gathering
- Reporting

System Administration

Software can be installed on existing staff PCs to enable administration tasks e.g.

- Finance Staff manage patient funds, DWP payments
- Procurement Staff deduct funds for patient purchases
- Create and manage patient accounts, password resets
- Configure patient permissions
- Manage permission groups
- Manage content e.g. Notices, FAQs, Patient Intranet content
- Approve or reject appointment/timetable requests
- Approve or reject visit booking requests

Devices

Speakers:

Thomas Best – Head of eHealth

Jim Irvine – Deputy Director of Security

Device Questions

For Discussion In Breakout Groups

1. Which areas of the hospital do we want devices/have a Digital Inclusion solution installed?
2. What Devices do we want in Hub Communal Areas?
3. Do we want Wall Mounted or Floor Mounted Devices in the Skye Centre?
4. What Devices do we want in Ward Communal Areas?
5. Do we want in Room Devices, and should these be in all patient bedrooms or based on Clinical Service?
6. Where on the Roadmap should In-Room Devices be?
7. Where do we want Video Visiting to take place?

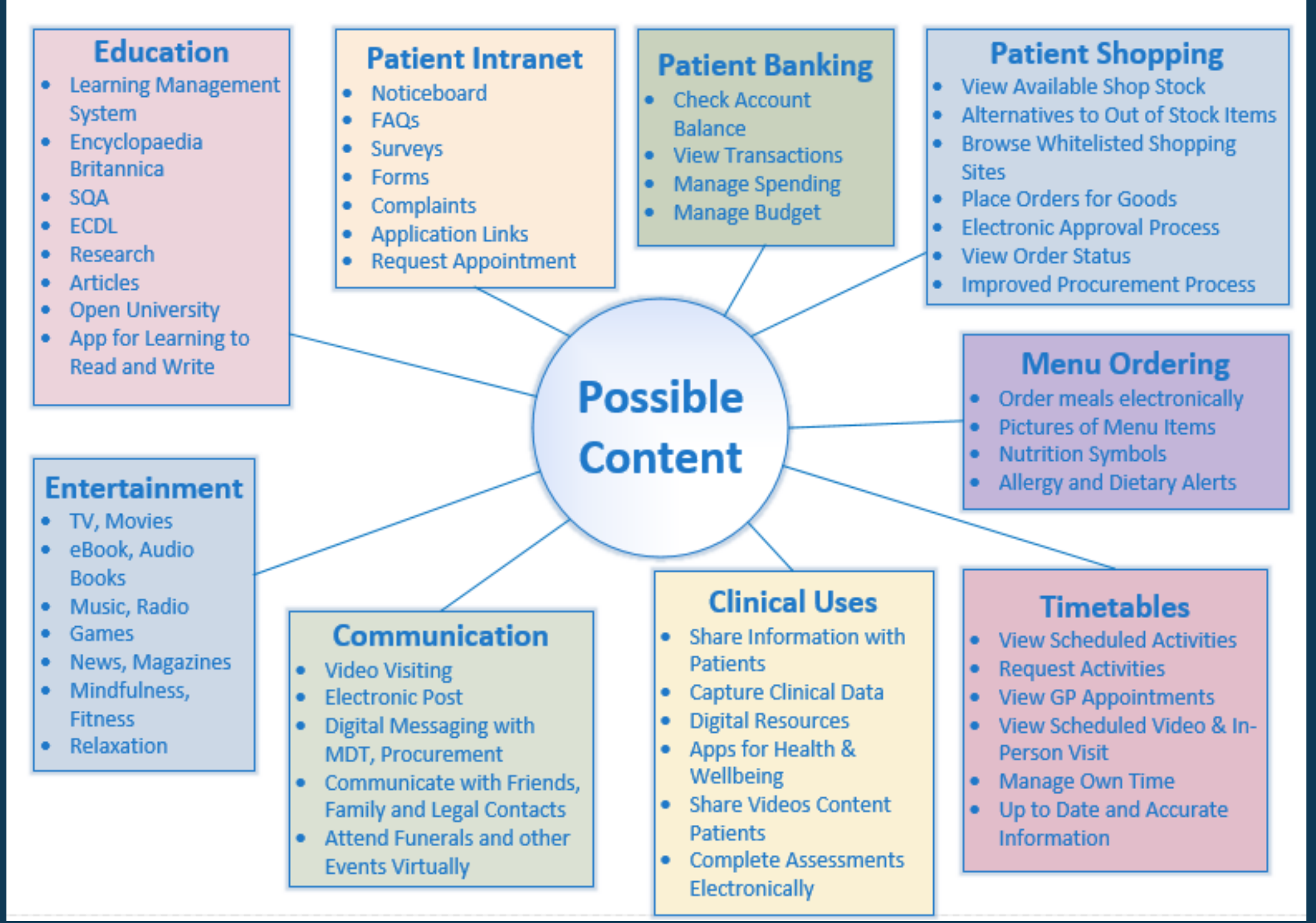
Breakout Group Session 1
Focus on Devices and Locations
20 Minutes


Comfort Break!
Back in 5 Minutes

THE RESULTS ARE IN...

Focus on Content

Focus on content



Education

UniLink

- Can add any Apps and Games required
- Can add links to external whitelisted websites
- Whitelisting done by supplier
- Provides a recording system for patient learning but not specifically the content
- Additional content would need to be added by TSH
- Additional systems e.g. Unify, Moodle etc required

Made Purple

- Can add any Apps and Games required
- Can add links to external whitelisted websites
- Whitelisting done by supplier
- Already have an array of learning content available
- Have developed their own Learning Management System
- No additional systems required

Patient Banking and Shopping

UniLink

- Comprehensive patient banking system
- Patients can view their account balance and account summary with a detailed transactions view
- Family can also send funds directly to the system
- Catalogue browsing experience similar to what is currently in place
- Patient needs to enter the details onto a separate system to place an order
- Supports stock management, reconciliations of patients' cash and links with EPOS systems.

Made Purple

- Spending money system designed to work alongside their shopping app
- Internet shopping offers a browse, click, and add to basket experience
- Future developments which would offer an experience more akin to the community
- Used alongside the RBS CMS system, Purple Wallet would meet the requirements of Finance and Procurement staff, and our patients.

Patient Comms and Messaging

UniLink

- Need to log onto a site to create and send messages
- Has inbuilt survey creation tools with integrated reporting tool
- The service is free of charge to the establishment. Typically, the sender (patient and contact) pays all fees
- Does not automatically translate patient post, however, the CMS Translate module can be used to translate messages and any other content across the system as required.
- Only one site, so contacts are banned from both post and video visiting, not one or the other

Made Purple

- Purple Post App
- Additional security of all content being kept within the Made Purple ecosystem and not going through third party systems
- App is also more user friendly and intuitive, offering a better user experience for both patients and their approved contacts
- Contacts can purchase post card credits via the app to use to send post. The patient can send one reply per incoming message free.
- Purple Post has inbuilt translation
- Contacts can be banned on Purple Post and not on Purple Visits and vice versa and require to be banned separately on each system if required
- The family/carer interfaces/apps are available in over 20 languages

Video Visiting

UniLink

- Has built in disassociations functionality
- Can also be used for booking in-person patient visits
- Highlights allergies and dietary requirements by associating warnings with patients/visitors
- Equipment would need to be sourced from a third-party supplier.
- Cost per call is slightly cheaper (paid by contact or establishment)
- No annual recurring module costs

Made Purple

- Disassociations functionality on roadmap
- Booking of in-person patient visits on roadmap
- Allergies/dietary requirements are a future development
- Requires the App user to identify themselves using facial recognition to enter the video call
- Blocks the ability to screen cast or take screenshots or recordings from the family members device
- Equipment provided

Entertainment

UniLink

- In-room equipment not provided, only the PICS set top box to attach to existing equipment, with keyboard and mouse
- TV/Monitor/All in One device would need to be purchased separately
- Will add additional content upon request and at an additional cost to the customer
- Third party system required - Unify Solutions
- User hours can be controlled as required

Made Purple

- Provide all required equipment
- Have a lot more content already available, having developed some of their own content themselves
- Continuously looking to add additional content and develop new elements of the system
- Customisable content and patients can add 'favourites'
- Subscription model being developed with content partner – similar to Netflix/Amazon Prime for on demand TV and movies
- Working with Audible to offer a restricted library of audio books
- Developed their own meditation tool, which offers unaided and guided meditation content

Timetabling

UniLink

- Existing list view of scheduled activities
- Can only be viewed by patients
- Managed by staff
- Displays the Patients planned activities for up to two weeks in advance

Made Purple

- Designing a bespoke calendar solution which will display in a calendar style layout, which both staff and patients can view and manage
- Purple Calendar app on roadmap to be rolled out later this year
- Will allow patients to add their own activities, Family members birthdays etc
- No limitation on display period

Menu Ordering

UniLink

- Well-established menu ordering system already in place with pictures, colour coding and nutrition symbols, with built in workflows
- Meals can also be assigned health and nutrition symbols, i.e. 5-a-day, as well as special dietary markings

Made Purple

- Forms-based system in place currently but are developing their own menu ordering system which will have similar functionality to the UniLink system, with a potential opportunity for being developed to our specific requirements.

Patient Property

UniLink

- Existing module for Patients Property, managed through CMS reception, where staff would update the patient's property lists
- The patient can view a list of their property items, filtering by items in their possession or items held in storage

Made Purple

- No current patient property module; however, they are keen to work with us to understand our requirements to develop a suitable solution
- This would link in with the patient shopping/Purple Wallet module, where items purchased by the patient would automatically be added to their property lists

Accessibility

UniLink

- Content and communication between patients and their approved contacts is not automatically translated, however, the CMS Translate module can be used to translate messages and any other content across the system as required.
- Picture attachments when it comes to options on the canteen and kitchen menu for dyslexia etc
- Option for audio for the in-room devices
- System content is accessed through icons on coloured tiles

Made Purple

- Purple Post has an inbuilt translation AI, which automatically translates any content posted between patients and their family and friends
- The Purple Post and Purple Visits Apps are also available in multiple languages
- Most of the content is viewable in multiple languages
- Any content added by TSH would need to be translated by ourselves
- Various accessibility tools have been applied across the system
- Developed their system with accessibility in mind, using colour coding and graphics to make the system simple and easy to use for all abilities

Technical Requirements

UniLink

- Whitelisting charged per patient per month irrespective of number of requests
- Unify adds any Sites/Apps/Games/Links etc, we wouldn't have the ability to do this ourselves
- User authentication via Biometric fingerprint system, alternative are available
- Security controlled through existing PLN controls for internet access
- Will require its own instance on our existing storage and back-up solutions – or Cloud Hosted option as additional cost

Made Purple

- Whitelisting charges per App/Site requested with 3 day turnaround target
- Content can be added by Supplier or TSH as required
- User authentication via unique identifier and password/PIN - future development of facial recognition for login purposes being explored
- Security controlled through the Purple MDM, removing risk of accessing the open internet
- Cloud based system with both on-site and offsite backups

Clinical Uses

Many interesting clinical uses for devices were highlighted during the requirements gathering process. The introduction of devices on wards could support sharing of data and other health related content directly with patients and enable patients to participate in clinical data collection. Although UniLink and Made Purple are not designed to be clinical systems, the devices could host some of this type of content as links to whitelisted sites can be added to the devices for patients to access.

The introduction of devices on wards introduces a whole host of possibilities for the delivery of content and information, and capture of data from patients, some of which is currently possible on the Made Purple and UniLink systems, with the ability to add forms, whitelisted websites, applications, and games as required.

Potential benefits include improved:

- Data collection
- Reportability
- Patient wellbeing
- Digital literacy
- Collaboration
- Engagement
- Clinical efficiency
- A patient experience more in line with general society.

Patient Partnership Group Consultation and Feedback

- Presentation on content and devices
- Demonstration of the type of solutions available
- Opportunity to use a ruggedized tablet with sample content
- Voting on priorities for content

2 x sessions September 2023

Results:

Highest: Shopping

Next: Education and Entertainment

Then: Banking, Menu Ordering, Clinical Uses

Not a priority: Patient Intranet and Timetabling

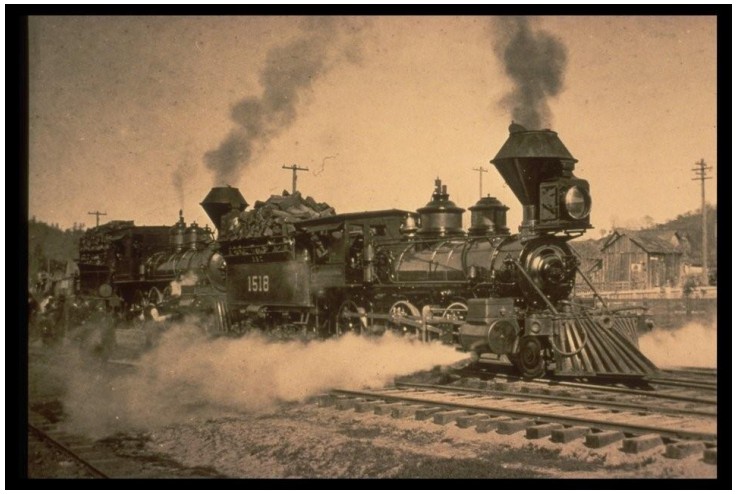
Content

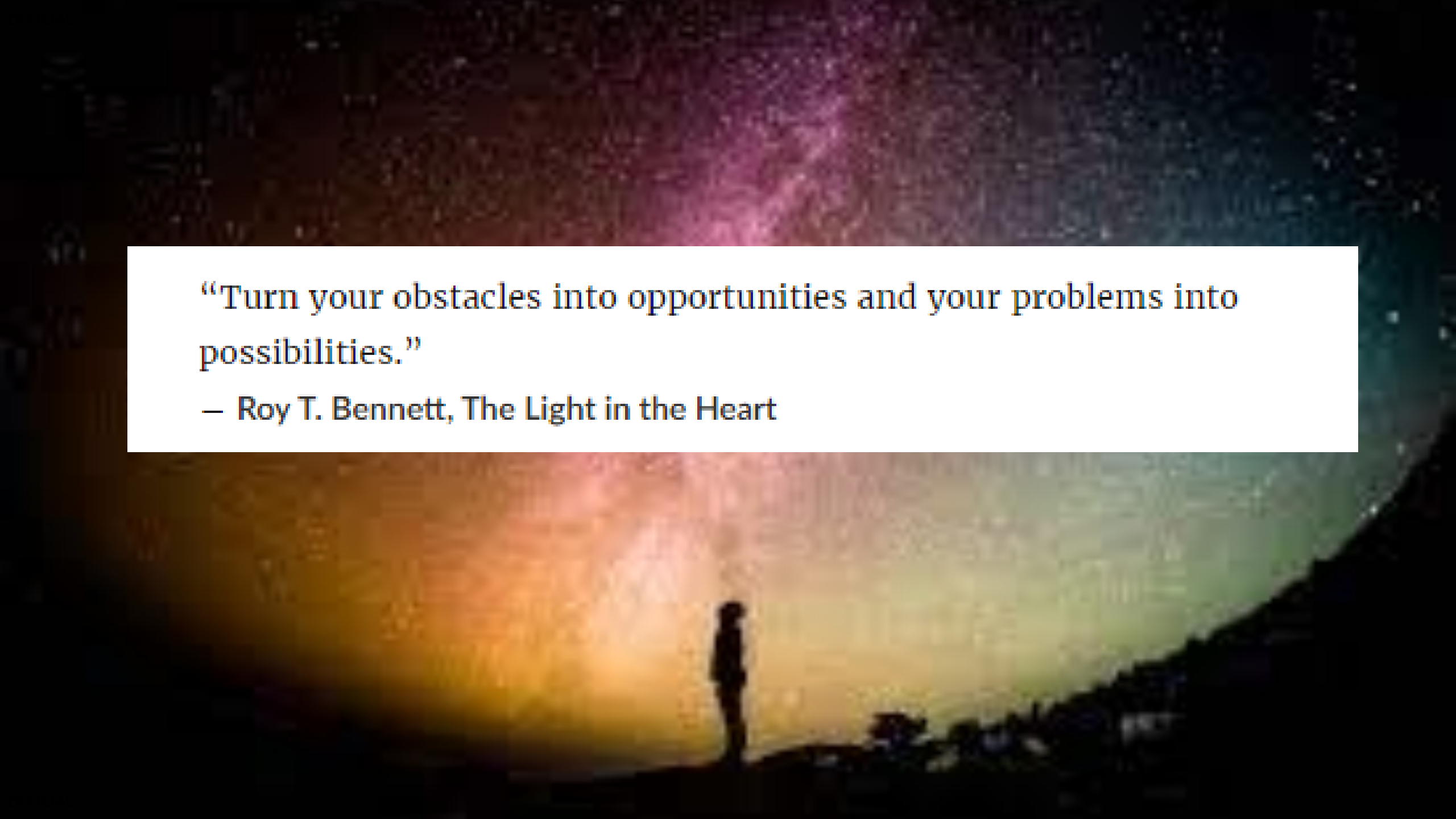
Speakers:

Hamish Fulford - Consultant Nurse, Psychological Services

Julie McDonald – Patient Learning Manager, Skye Centre

Moving from the Victorian to the Digital Age




“Turn your obstacles into opportunities and your problems into possibilities.”
— Roy T. Bennett, The Light in the Heart

Content Questions

For Discussion In Breakout Groups

Within the Digital Inclusion Programme, there are many individual projects that will require extensive work to configure and implement.

Not all content can be rolled out straight away all at the same time, therefore we need to determine the priority in which the content is rolled out within the Roadmap.

Content ranked as higher priority will be focused on first, with additional content being rolled out over time.

Content is dependent on the Devices and their Locations.

Breakout Group Session 2
Focus on Content
15 Minutes


Comfort Break!
Back in 10 Minutes

THE RESULTS ARE IN...

Resource Requirements

Infrastructure Team

- eHealth do not have the resources to do whitelisting or to manage content – Whitelisting as a Service (WaaS) is essential
- Additional staff resource required to review and customise any whitelisted apps/sites, as well as the deployment and swap out of any devices across the site

Cloud Hosted v On Premise

- Cloud hosting would reduce the local overheads needed to maintain the system
- On-premise systems, back-up solutions and server licensing would need additional local resources to manage and maintain. These costs would need to be factored in as part of the overall cost of an on-premise system

System Monitoring and Management

- NetSupport for live monitoring – not eHealth responsibility to monitor patient activity, needs clinical knowledge
- Resource required for monitoring patient digital mail and video visits – Security/Nursing staff
- Resource required for approving external contacts, setting up and managing of accounts, configuration of individual patient and group permissions
- Resource required for managing Patient Intranet content, forms, surveys, notifications, FAQs, education resources etc

Resource Implications:

- Project Management
- Management of the system and devices
- Monitoring aspects of any of the solution used
- Redesign of workflows
- Content management
- Managing security
- Upskilling of staff and patients

Based on the lessons from other High Secure Services it is essential that dedicated teams (Project and BAU) will be required to take this forward comprising of the following roles, some of which will be new posts.

Role	Project	BAU
Programme Manager	✓	
Project Manager	✓	
Project Administrator	✓	
Procurement Lead	✓	
eHealth Technical Lead – other roles dependent on whether hosted in cloud or on-premise	✓	✓
System Administrator	✓	✓
Clinical Lead(s) - nursing and others	✓	✓
Patient & Carer representatives	✓	✓
Patient Intranet Content Administrator	✓	✓
Security Lead	✓	✓
Comms monitoring staff	✓	✓
Estates Lead	✓	✓
Business Change Lead	✓	✓
Learning and development lead - Patients	✓	✓
Learning and Development Lead - staff	✓	✓
Other subject matter experts depending on module being implemented: e.g. Finance, Catering.	✓	✓

Pricing Models, Funding and Procurement

Speakers:

Robin McNaught – Director of Finance and eHealth

Stuart Paterson – Head of Procurement

Pricing / Funding

Funding requirement – preferred product dependant

- Capital Implementation & Annual Revenue
- Annual Revenue only

Year 1 > £200k – likely SG funding request

Additional / ongoing

- Dedicated staffing demand
- Recurring product / provision costs

Timescale

- Planned underway 2024/25
- Pace will be funding dependant

Procurement Process

- Routes to Market - Framework or Open Regulated Tender
- Funding Dependant – May require either smaller tender processes or establish our own framework contract with Lots
- Timescales – Approx 6 months from tender document development to contract award. Smaller processes, less time
- Contract Implementation – Dedicated Programme resource will be required

Vision and Roadmap

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	26 October 2023
Agenda Reference:	Item No: 18a
Sponsoring Director:	CEO
Author(s):	Head of Planning, Performance and Quality
Title of Report:	Anchors Strategy 2023- 2026
Purpose of Report:	For approval

1 SITUATION

Scottish Government have commissioned all NHS Boards to produce an Anchors Strategy as an initial 3 year strategy and be framed with reference to how it will support a 'prevention' public health approach and contribute to both community wealth building and reducing child poverty..

2 BACKGROUND

Scottish Government in their commission to NHS Boards in June 2023, requested that the NHS Boards Anchors Strategic Plan should set out the following information along with any other relevant information on their anchor role and activity:

- The actions taken and/or plan to take to:
  - maximise local, progressive procurement of goods and services;
  - provide fair work opportunities for new employment and for existing staff;
  - use and/or dispose of your land and assets for the benefit of the local community and local economy (if relevant to your Board).
- The governance arrangements within the NHS Board to progress your Anchors Strategic Plan.

The Anchors Strategic Plan will also include data to provide a baseline in relation to workforce and local procurement. The plans are to be submitted to Scottish Government by 27th October 2023.

3 ASSESSMENT

An Anchors Strategy short life working group (SLWG) was established with partnership representation to take forward the development of TSH strategic plan. TSH inaugural Anchors Strategy is attached as appendix 1. The strategy will be added to TSH Board work plan, with dedicated reporting annually.

4 RECOMMENDATION

Board members are invited to approve the Anchors Strategy.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	The ADP 2023/24 references the Anchors Strategy and has a commitment to deliver this in year
Workforce Implications	The workforce section of the strategy provides an outline of how TSH aims to focus workforce activity to support an anchor approach.
Financial Implications	N/A
Route to Board Which groups were involved in contributing to the paper and recommendations.	Anchor Strategy circulated to CMT for comment prior to Board
Risk Assessment (Outline any significant risks and associated mitigation)	N/A
Assessment of Impact on Stakeholder Experience	N/A
Equality Impact Assessment	N/A
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	N/A
Data Protection Impact Assessment (DPIA) See IG 16.	**X There are no privacy implications.** □ There are privacy implications, but full DPIA not needed □ There are privacy implications, full DPIA included.

Anchors Strategic Plan 2023 - 2025

NHS Board: The State Hospital

Contents

1 Introduction

Scottish Government have commissioned all NHS Boards to produce an Anchors Strategic Plan as an initial three year strategy to demonstrate how The State Hospital plans to take action to contribute to community wealth. There is now significant evidence that the fundamental causes of health inequalities are a result of power, income and wealth imbalance. Through making positive changes to political and social decision, this inequality may be reduced.

This strategy seeks to demonstrate how The State Hospital can contribute to reducing health inequalities. The State Hospital is a psychiatric Hospital that provides care and treatment in conditions of high security for around 140 patients from Scotland and Northern Ireland. It is situated in a rural campus, on one site in South Lanarkshire local authority area.

2 Wellbeing Economy

A wellbeing economy is an economy that puts people and planet at its heart. The emphasis is on sustainable and inclusive growth rather than traditional Gross Domestic Product. In its Programme for Government, Scottish Government has identified the development of the wellbeing economy as a strategic goal to achieve economic growth in Scotland that is inclusive. This means growth that combines increased prosperity with greater equality, creates opportunities for all and distributes the benefits of increased prosperity fairly.

3 Community Wealth Building

Community wealth building is a practical approach to a wellbeing economy; it is focused on moving wealth and power back to the local economy. Thus creating more local employment and opportunities The Scottish Government plans to introduce community wealth building legislation in the future. There are five fundamental pillars or principles of action that can support community wealth building in Scotland:

1) Inclusive ownership – development of local community organisations and shared ownership of local economy.
2) Workforce – recruitment from lower income areas and progression route for staff.
3) Finance – local economic policy to keep wealth in local area.
4) Sustainable use of land and property – social justice use of land and property, reducing impact on the climate.
5) Progressive Procurement – using the estate and land to put wealth back to local communities.

4 Anchor Organisations

Anchor institutions are large organisations that are unlikely to relocate and have a significant stake in their local area. They have sizeable assets that can be used to support their local community's health and wellbeing and tackle health inequalities, e.g. through procurement, training, employment, professional development, and buildings and land use.

The State Hospital, as an Anchor NHS Board has developed this plan to describe the actions we plan to take, baseline metrics associated and governance arrangements. The initial themes include:

- Progressive Procurement - The State Hospital can direct investment into the local region through procurement practices. It may be possible to consider giving local suppliers greater weight in procurement processes, which in turn can create new employment locally.
- Employment - The State Hospital is a relatively large local employer within an area of deprivation. Development of recruitment practices to encourage community members to consider employment in The State Hospital would be useful to consider.
- Sustainable use of land and property - consideration given to the use of land and sustainable practices.

5 Progressive Procurement

Sustainable public procurement aims to make the best use of public money. The sustainable procurement duty outlined in the Procurement Reform Act 2014 requires NHS Board's to consider how they can improve the social, environmental and economic wellbeing of an area with a focus on reducing inequalities through procurement practices.

Within The State Hospital, community wealth building is built into our Procurement Strategy and due to the number of contracts we have below the £50k threshold we are well placed to target Small Medium Enterprises (SMEs) to bid for these opportunities. All tenders or quick quotes published contains 'fair work first' criteria ensuring bidders must comply with the real living wage, have suitable Human Resources (HR) policies and practises. All regulated tenders contain a Community Benefits section encouraging bidders to support this agenda with further details. Within our annual procurement report we are expected to report on contracts that contain 'fair work first' along with spend with SMEs and supported businesses.

The State Hospital's Board current third party spend is 73% with SMEs and other public bodies. The specific definitions are still being worked out by a National Procurement Task and Finish Group. Given the unusually high spend with other public bodies there is limited scope to significantly increase our SMEs spend. Spend with local businesses within the Lanarkshire (ML) post code area is not yet defined on the spend analyser, this is being reviewed nationally. In financial year 2022/23 The State Hospital spent £30k with a supported business.

In terms of payment of invoices, the Procurement Reform (Scotland) Act 2014 requires contracting authorities to set out in their Procurement Strategy how they intend to ensure all payments made to contractors and sub-contractors are paid within 30 days of receipt of a valid invoice. Analysis of The State Hospital invoice payment reveals that we are compliant with 98% of invoices paid within 30 days and 90% of these within 10 days.

Strategic Commitments to support Progressive Procurement.

The State Hospital will:

- Continue to report on all regulated tenders, contracts that contain 'fair work first' and spend with SMEs and supported businesses.
- In awarding contracts, The State Hospital will, if proportionate and relevant to the contact, consider how any community benefits may be delivered via the contracts.
- Continue to proactively engage with local suppliers with a particular emphasis on below regulated threshold opportunities.
- The State Hospital will engage with the national task and finish group developing baseline metrics and will develop The State Hospital specific metrics to comply with national expectations.

6 Employment

The State Hospital has an agreed three-year workforce plan in place. The plan will continue to evolve over this time as changes are brought forward to terms and conditions, e.g. the implementation of the 36 hour working week, protected learning time and Agenda for Change review.

There is a Workforce Governance Group in place to manage workforce planning and monitoring. This is aligned to the national workforce planning pillars of: Plan, Attract, Train, Employ and Nurture. Workforce supply remains a priority area for the organisation.

The State Hospital is a relatively large local employer within an area of deprivation. Development of recruitment practices to encourage community members to consider employment in The State Hospital is an active aspect of The State Hospital recruitment strategy.

7 Current Workforce Profile

Outline of staffing profile by local postcodes as of 31 July 2023.

Postcode	Count	% of workforce
AB (Aberdeenshire/ City)	*	<1%
DG (Dumfries and Galloway)	*	<1%
EH (Edinburgh)	58	8%
FK (Stirlingshire)	14	2%
G (Glasgow)	42	6%
KA (Ayrshire and Arran)	6	1% (rounded up)
KY (Fife)	*	<1%
ML (Lanarkshire)	589	82%
PA (Renfrewshire)	9	1% (rounded up)

*Less than five

The State Hospital previously set an ambition to facilitate two apprenticeships. These are both in place (one within the Workforce Directorate who has now moved into a full time permanent role and one within Clinical Quality Department). The post holders both hold ML postcodes.

In relation to SVQs, of those who have either recently completed an SVQ qualification or are currently undertaking a qualification that is funded by the organisation.

Postcode	Count	% of those undertaking SVQ
AB (Aberdeenshire/ City)	0	
DG (Dumfries and Galloway)	0	
EH (Edinburgh)	*	*
FK (Stirlingshire)	0	
G (Glasgow)	*	*
KA (Ayrshire and Arran)	0	
KY (Fife)	0	

ML (Lanarkshire)	16	89%
PA (Renfrewshire)	0	

*Less than five

This includes Level 2 Care SVQ and all new security operators are supported to undertake the Level 3 Custodial Care SVQ.

There also eight current Nursing Assistants carrying out their nursing degree through the Open University, with a further four starting in October 2023. 11 out of 12 hold ML postcodes.

8 Recruitment and Retention Strategy

The Board's recruitment and retention strategy which was reviewed and endorsed in June 2023, outlines various measures to support our community through employment with the Board. This strategy outlines in detail the actions that will be taken to attract, train and retain staff for The State Hospital.

9 Careers Events

Attendance at local schools and further education providers to provide students with the insight into key roles within The State Hospital is encouraged. At these events opportunities would be given for students to understand what The State Hospital can offer an employee which may be unique to other employment choices. Where possible during these events it would be positive for the attendees representing The State Hospital to display their professional skills as an example of what The State Hospital offers and the range of career opportunities.

10 Local Community

The State Hospital recognises its position and social responsibility as a large employer in a rural area. There is common misconception that careers within the NHS comprise of clinical roles only, this misconception will be addressed and the full extent/range of employment offered by The State Hospital will be marketed.

To support recruitment campaigns, consideration could be given to aligning with local community engagement talks coordinated by the communications department to promote the range of employment opportunities within The State Hospital.

On request, the Board's Communication Department attend local community groups to discuss the work at The State Hospital, what we do, the range of staff and volunteers who support the hospital and the activities which take place. These are intended to increase awareness in the local community of the work we do. More dedicated community engagement take place for specific projects e.g. recent upgrade to Closed Circuit Television (CCTV).

Additionally, where appropriate we would hold 'open day/recruitment days' at an on-site location. This would enable potential employees to visit and understand the opportunities of working at The State Hospital. Specific actions include:

- Resources available 'off the shelf' for teams to use for career events.
- Maximising attendance in education providers to ensure The State Hospital is visible and an employer of choice.
- Specific local community outreach using local media opportunities.
- Analysis by job role where we are making successful appointments from, at job/role level.

Consideration of opportunities for 'Active Travel' initiatives will be given, linked to the organisation's environmental responsibilities forms part of the strategy, ensuring that local communities have accessible public transport links to The State Hospital.

11 Apprenticeships/Training

A number of strands of additional recruitment streams will be considered fully, including:

- Use of Annex 21 (trainee terms and conditions), enabling the use of trainees to develop into roles.
- Ensure that the recommendations from 'Fair and Health Work for All', the Scottish Government's health and work strategy, are taken in to account.
- Social inclusion initiatives, such as 'Best Start, Bright Futures', part of the Scottish Government's Tackling Child Poverty Delivery Plan, where apprenticeship opportunities will available for individuals over age 25 across NHSScotland.
- Initiatives to enable young people to enter employment are taken into account, including modern apprenticeships and Project Search.

There are areas of good practice established within The State Hospital and this should be developed to ensure that consistent reliable guidance is available for managers at the point of recruiting as to the benefits and responsibilities of employing apprenticeships into appropriate professions. This alongside other measures described above are an important enabler of the 'first step' into working for the NHS:

- Ensure line manager have access to information about their workforce demographics through Tableau.
- Maximising opportunities for access to employment at The State Hospital as described in the Workforce Planning section of the Strategy.
- Develop apprenticeship placement opportunities within Nursing to both upskill staff and provide a seamless upskilling of staff (from three year workforce plan).
- Explore apprenticeship opportunities within all areas of The State Hospital, in particular Estates (from three year workforce plan).
- Development of good practice organisational approach to succession planning/talent management.

12 Encouraging and Supporting Employees with Disabilities

In 2023, a group of managers, HR and occupational health colleagues from The State Hospital engaged with Business Disability Forum to develop organisational guidance in relation to supporting employees who have disabilities. The objective of this work was to develop organisational awareness of the legal duties in relation to reasonable adjustments and develop guidance to support staff to remain healthy and supported at work.

The recruitment and retention strategy was thereafter developed to reflect the need to ensure all recruitment documentation is inclusive, provides information regarding the physical and security requirements of roles within The State Hospital, including the need to partake in specialist training such as Prevention and Management of Violence and Aggression (PMVA) and Breakaway.

13 Salary Sacrifice Scheme

Recent introduction of 'Cycle to Work' scheme has encouraged employees to purchase bikes and benefit from the tax savings associated with a salary sacrifice arrangement. Local suppliers of bicycles are within the range of retailers where employees can receive a voucher to purchase a bike.

14 Fair Work

Fair Work's main five dimensions are:

1) Effective Voice.
2) Opportunities.
3) Security.
4) Fulfilment.
5) Respect.

NHS Boards though their strategic aims, workforce plans, the staff governance standards, organisational values and compliance with Agenda for Change terms and conditions already provide work which complies with a number of these dimensions.

15 Volunteers

The Scottish Government National Volunteering Framework, 'Volunteering for All' (2019), was developed over a number of years in partnership with colleagues from both the volunteer and community sector, local government and NHS, with academics, social researchers and volunteers contributing to the publication.

The framework advocates that voluntary opportunities available:

- Are appropriate for a diverse range of people.
- Foster mutually beneficial relationships.
- Are not roles which replace work undertaken by staff.

The Person Centred Improvement Steering Group is responsible for the following:

- To ensure the recruitment process follows national guidelines and mirrors that of staff.
- To monitor the number of volunteers engaged in the hospital and the range of roles in which they participate.

Currently 10 volunteers (some with multiple roles) provide a wide range of input to complement service delivery across the hospital: five of whom live in the ML postcode area covering either North or South Lanarkshire. Three of these five live within 15 miles of the hospital.

The Board liaise with Voluntary Action South Lanarkshire who support the advertisement of opportunities and assist in helping people apply for these roles. They also place adverts on Volunteer Scotland on our behalf.

Strategic Commitments to support employment.

The State Hospital will:

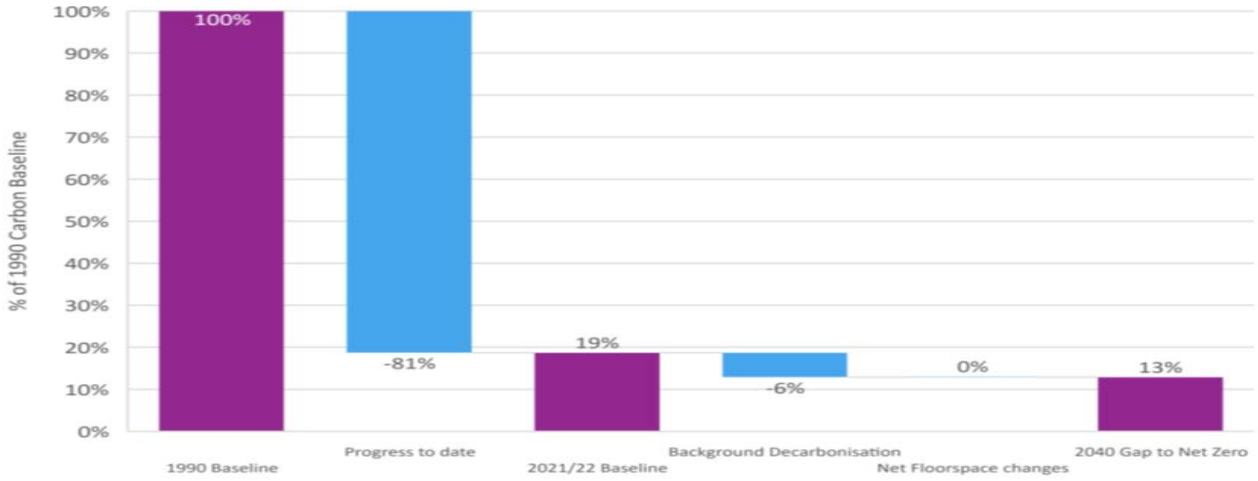
- Continue to analyse workforce data together with local demographics to support targeting of underrepresented groups within recruitment drives.
- Promote and adopt the new Once for Scotland Polices on flexible Working.
- Continue to develop and promote the 'The State Hospital Staff and Volunteer Wellbeing Strategy' including offering targeted support for lower paid groups e.g. money welfare and advise to staff and credit union support.
- Continue to pay the real living wage for all staff.

- Continue to develop staff training and development opportunities with a focus on skills enhancement for staff development to avoid barriers to employment.
- Carry out the Fair Work self-assessment tool and seek to deliver on the Fair Work Principles.
- Continue to deliver Leadership and Management Development opportunities.
- Develop The State Hospital staff engagement approach through Organisational Development to better tailor and understand the needs of staff.
- The State Hospital will engage with the developing baseline metrics for workforce and produce The State Hospital specific data to comply with national expectations.

16 Sustainable Use of Land and Property

The State Hospital recognises the role it plays in NHSScotland's approach to the climate emergency as set out in DL (2021) 38. The organisation has achieved its 2030 target of a 75% reduction from a 1990 baseline target.

There is considerable opportunity for The State Hospital to reach the net zero target by



2040.

The Anchors Strategic Plan also sets out to support The State Hospital Board ambitions on net zero targets and sustainable development. As part of the strategy, The State Hospital will consider:

- The positive management of land and assets.
- Productive reuse of land and buildings.
- Collaboration and partnership.
- Sharing information.
- Supporting economic growth.
- Community aspiration.

'Climate change poses a catastrophic threat to humanity and the natural systems that underpin our lives. It is obvious that tackling climate change will have a positive impact on human health'.

As an organisation dedicated to improving and protecting physical and mental health and wellbeing, our hospital must be at the forefront to tackle the climate emergency and the environmental crisis.

Our aim is to become a hospital which is both environmentally and socially sustainable. A hospital that improves the environments, opportunities, life chances, health and wellbeing of every citizen in our area and fully contributes to a more cohesive, resilient and net zero society in a just way that contributes to population wellbeing and a reduction in health inequalities.

NHS National Services Scotland procured a 'Once for Scotland' approach to provide analysis for all NHS Boards carbon management. The State Hospital has received the

formal report from Jacobs (an external carbon management organisation) and is planning actions in support of decarbonisation. The State Hospital Climate Change and Sustainability Group will establish further actions and oversee the implementation of the action plan.

The State Hospital are currently developing a Transport Strategy that will include how The State Hospital Board will meet the 2025 targets for car/light commercial vehicles and 2032 target for heavy vehicles to decarbonise the fleet. The State Hospital have a relativity small fleet of vehicles, which consists of seven light commercial and two heavy vehicles. Of the seven light commercial vehicles two are electric, with the remaining five powered by fossil fuel. The Procurement Department are actively involved with assessing the most advantageous route for the replacement of four of these vehicles to further decarbonise the fleet. The two heavy vehicles are tractors used for site maintenance.

Decarbonising heat will be the biggest challenge for the site to reach net zero.

Improvements to building fabric and the heating network have helped to reduce thermal demand, therefore any further reduction in emissions will need to focus on generation assets.

While the biomass boiler was installed in 2009, the LPG (Liquefied Petroleum Gas) boilers were only installed in 2017. If the site wishes to maximise the economic output of their assets, it is likely that the use of fossil fuels will continue for quite a number of years.

Additional challenges include the high security nature of the site which mean that the design specification of the site meets standards that may not be required by any other Health Board in Scotland.

Potential future use of green hydrogen in place of LPG being developed. This would not require major changes on site e.g. utilise existing tanks (installed in 2017) and burner head replacement required. Such systems could potentially utilise the existing low temperature heat networks only requiring a change out of generation assets. There is considerable space on site for both horizontal and vertical bore holes. An assessment of the geomorphology of the site is required to verify this.

A backup system will still be required to provide redundancy for the site. That will most likely need to be a fluid fuel which can be stored onsite. Both bio-LPG and HVO (Hydro-treated Vegetable Oil) would be the most likely option, though as the biofuel market develops and grows, other options may become more viable.

There is considerable space available for both solar and wind generation. The State Hospital Climate Change and Sustainability Group will review actions associated with the potential development of renewable energy using these sources.

The following actions will be taken forward to support decarbonisation in 2023/24:

- LED (light-emitting diode) lighting for grounds has been purchased and due to be installed over the summer period.
- Electric vehicles (EV) charging points: awaiting final commissioning certificates. KWH (kilowatt hour) charging rates to be determined, likely to be similar to existing electricity charges plus small amount to cover maintenance costs. The State Hospital will provide advice on usage (not enforceable).
- Bid submitted to ‘switched on fleets’ for further six external charging points, outcome expected in summer 2023.

Bid due to be submitted to the Scottish Central Government Energy Efficiency Grant Scheme for internal LED lighting by end Q1. Outcome expected in Q2, with spend by end 2023/24.

NHSScotland have introduced a new NHSScotland Environmental Management System (EMS) provided by RiO in June 2021. Individuals at The State Hospital have been given the relevant access rights and training for the system, and have commenced with the population of the EMS for the Board.

Reporting on the EMS is through The State Hospital Climate Change and Sustainability Group and is further reported into the Board and Scottish Government.

The geographic location of the site results in periodic extreme, sub-zero winter conditions, which are occurring with increasing frequency. Such weather events may prove to be a challenge for some low carbon heat technologies currently available in the market and may limit the opportunities available to the site.

Furthermore, the rural location of The State Hospital limits the opportunity of district heating systems.

A climate change risk assessment has been completed in 2022/23.

- The Climate Change Adaption Plan will be developed following the risk assessment to ensure resilience of service under changing climate conditions will be completed for Q4.
- The State Hospital has mapped the estate and has developed a biodiversity report in collaboration with other National NHS Boards.

Strategic Commitments to support sustainable use of Land and Assets.

The State Hospital will deliver on the commitments set out in the Annual Delivery Plan 2023/24, these include:

- Continue to develop the Carbon Management Action Plan.
- Develop the Transport Strategy.
- Continue to develop the Climate Change Adaptation Plan.

17 Governance

The State Hospitals Board will take oversight of the Anchors Strategy, ensuring that adequate resources are committed to deliver its goals. The Board will have responsibility of approving the strategy, and monitoring its progress and related activity. This will be added to the Board workplan, with dedicated reporting annually.

The State Hospital Anchors Strategy has three key themes, and regular detailed review will be enabled through the Board's standing committee framework.

1) Progressive Procurement
   The Audit and Risk Committee receives annual reporting on all procurement activity. The aims of the Anchors Strategy will be embedded into reporting, and areas of progress monitored. The committee will also receive additional dedicated progress reporting on this strategy, at a six month interval. Within the management reporting structure, this will be monitored regularly through the Finance, eHealth and Audit Group, which can escalate reporting to the Corporate Management Team (CMT).

2) Employment
The Staff Governance Committee receives assurance reporting across a wide range of metrics, demonstrating organisational commitment to the Staff Governance Standards. Progress reporting on the Anchors Strategy will be received every six months, aligning with existing workforce reporting to provide assurance that there is continued focus, and realisation of the goals. This should align with reporting to the Partnership Forum to ensure that there is opportunity for input and reengagement with joint staff side colleagues. The Workforce Governance Group is the key mechanism within the management reporting structure to take action to ensure progress is made, and can escalate reporting to the CMT.

3) Sustainable Use of Land and Property
Annual reporting is submitted to the Board across Climate Change and Sustainability, and the Board has appointed a Non-Executive Director Champion. In addition, and to align with reporting on Progressive Procurement, six monthly progress reporting will be routed through the Audit and Risk committee. The State Hospital Climate Change and Sustainability Group manages progress, and can escalate reporting to the CMT.

In addition to the above, monitoring progress in relation to the Anchors Strategy will be added to the key performance indicators reviewed within quarterly directorate meetings, which are led by the Chief Executive Officer.

18 Definitions

- Small Medium Enterprise (in our context usually Scottish) – 1 to 249 employees.
- Supported Business – workforce must have at least 30% disabled or disadvantaged staff.
- Local Business – requires final confirmation, however territorial NHS Boards are using their local council area within their Anchors Strategies.
- Local – North and South Lanarkshire Local Authority Areas (ML postcodes).

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	26 October 2023
Agenda Reference:	Item No: 18b
Sponsoring Director:	Chief Executive
Author(s):	Head of Corporate Planning and Performance
Title of Report:	TSH Annual Delivery Plan 2023/24
Purpose of Report:	For Noting

1 SITUATION

Scottish Government requested all NHS Boards to prepare an Annual Delivery Plan (ADP) to outline TSH priorities and key actions over the period 2023/24. This was submitted to Scottish Government in June 2023. Feedback has now been received, appendix 1.

2 BACKGROUND

As NHS Scotland seeks to recover from the pandemic, the focus of service planning is to recover services to a sustainable and affordable system. The planning objectives outlined by Scottish Government for 2023/24 are to:

- Make rapid improvements in capacity and sustainability to support system performance through 2023 and in preparation for winter 2023/24
- Make progress in delivering the key ambitions in the NHS Recovery Plan
- Continue innovating and transforming the NHS for the future.

3. ASSESSMENT

The Annual Delivery Plan outlines what TSH will deliver across the year 2023/24. Scottish Government, in commissioning the plan, invited NHS Boards to outline how they intend to take forward activity to progress the Recovery Drivers, integrating work with the Care and Wellbeing Portfolios where possible. TSH ADP also reflects the requirements to outline plans to take forward Finance and Sustainability, Workforce, Value Based Health and Care and other programmes.. The ADP forms part of the governance and sponsorship arrangements with Scottish Government. Quarterly reports on progress will be submitted to Scottish Government throughout the year to update and discuss delivery and emerging priorities and issues

Scottish Government have indicated in the feedback latter that they are satisfied that the 2023/24 ADP meets the requirements and provides clarity and a shared understanding on what will be delivered by TSH in the period.

In addition, Scottish Government requested NHS Boards to complete a Winter Preparedness Checklist to provide assurance that resilience planning was in place in preparation for winter. TSH

submitted this Winter Plan by the 22nd September as requested. NHS Scotland's winter resilience priorities are consistent with last year, with a focus on preparations to support patients, citizens and staff through seasonal increase in demand.

In completing the checklist, we were requested to provide a current state level of readiness alongside a short statement on the rationale for that classification for each assurance statement. All TSH responses to assurance statements have either been 'Yes' – the statement is true for the Board or N/A – the statement is not applicable to TSH. The plan did not highlight any further areas where additional action planning would be required.

3 RECOMMENDATION

Board members are asked to:

- Note the content of the feedback letter from Scottish Government
- Note the submission of the Winter Preparedness Checklist

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	The Annual Delivery Plan outlines TSH priorities for delivery over 2023/24.
Workforce Implications	The plan outlies the key strategic responsibilities for TSH in terms of workforce
Financial Implications	The plan outlies the key financial responsibilities for TSH
Route To The Board Which groups were involved in contributing to the paper and recommendations	Direct to Board
Risk Assessment (Outline any significant risks and associated mitigation)	No formally assessed
Assessment of Impact on Stakeholder Experience	The plan sets out the key deliverables for TSH and will be monitored 1/4ly by SG
Equality Impact Assessment	An EQIA is not required
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do)	n/a
Data Protection Impact Assessment (DPIA) See IG 16	Tick One √ There are no privacy implications. □ There are privacy implications, but full DPIA not needed □ There are privacy implications, full DPIA included

Annual Delivery Plan 2023/24

NHS Board: State Hospital

CONTENTS

INTRODUCTION

This Annual Delivery Plan (ADP) details high level priority actions that The State Hospitals Board for Scotland (TSH) will progress in year 2023/24. The ADP is part of the NHS Scotland planning framework and is aligned to the Medium Term Plan (MTP). The MTP describes the three-year planning cycle for the organisation though to 2026.

Linkage is made, as far as possible, with the Recovery Drivers, and the Care and Wellbeing Portfolio ambitions, as set out by the Scottish Government Health Department (SGHD) (Appendix A). Further alignment to this plan may be necessary following the publication of The Mental Health and Wellbeing Strategy for Scotland later this year.

TSH is the national high security forensic mental healthcare provider for Scotland and Northern Ireland. The organisation provides specialist individualised assessment, treatment and care in conditions of high security for male patients with major mental disorders and intellectual disabilities. The patients, because of their dangerous, violent or criminal propensities, cannot be cared for in any other setting. Working closely with partners in the Forensic Network for Scotland, the organisation is recognised for high standards of care, treatment, innovative research and education.

The vision of TSH is to:

- excel in the provision of high secure forensic mental health care
- achieve positive patient outcomes
- ensure the safety of staff, visitors, patients and the general public
- strive to be an exemplar employer

The values of TSH are aligned with NHS Scotland:

- care and compassion
- dignity and respect
- openness, honesty and responsibility
- quality and team working

The twin aims of TSH are:

- the provision of a safe and secure environment that protects staff, patients and the general public
- the delivery of high quality, person centred, safe, effective care and treatment

In planning for the immediate term, the following success factors are identified as priorities:

- workforce sustainability, culture and organisational development
- clinical outcomes
- physical health and health inequalities
- financial sustainability
- data and evidence based decision making
- stakeholder and wider public trust and confidence in safety and security
- staff satisfaction

The ADP incorporates national priorities requested by the Mental Health Directorate (sponsor team), SGHD priorities, alongside internal organisational planning priorities, into a year one plan.

SECTION A: RECOVERY DRIVERS AND STATE HOSPITAL PRIORITIES

1 Mental Health

The core clinical focus of TSH is to deliver forensic mental health care as part of normal business. Oversight and governance of care and treatment metrics is monitored through the Clinical Governance Committee and onward to the Board. A summary of the clinical governance data and measures is contained within the MTP.

The following sections of this ADP are the combined and collective actions that TSH and the sponsor team consider as ongoing, additional or new to the 'business as usual' approach to mental health care and treatment within the organisation for the coming year.

No.	Board Action
1.1	**The Mental Health and Wellbeing Strategy for Scotland** The Mental Health and Wellbeing Strategy for Scotland was published in June 2023. An accompanying delivery plan will be developed in due course. Any alignment required as a result of this plan will be factored into the MTP planning process. • TSH will review the associated delivery plan to assess if there are further actions to align the organisational aims with those of the national direction for mental health in Scotland.
1.2	**Forensic Mental Health in Scotland: New Strategic Planning and Governance Structure** The Independent Review into the Delivery of Forensic Mental Health Services was published in February 2021. The review made 67 recommendations, including the creation of a new forensic NHS Board for Scotland. Following an extensive option appraisal process, it was agreed that a new Strategic Planning and Governance structure will be formed in 2023. TSH operates within a wider forensic system and connects with a range of partners across health, social work, criminal justice and independent advocacy. The landscape is complex; the creation of a collective approach should enable greater singular cohesion from a planning and delivery perspective. 'Once for Scotland' approaches could be applied to resolve longstanding issues such as bed capacity, transfer of patients from custody settings, women's service provision, and future changes resultant from the Mental Health Law Review (September 2022). • TSH will actively collaborate in the design, structure, formation and delivery of the whole system new Strategic Planning and Governance structure for forensic mental health in 2023.
1.3	**Health and Care (Staffing) (Scotland) Act 2019** 'The Act' aims to enable high quality care and improved outcomes for patients. It places duties on NHS Boards, care service providers, Healthcare Improvement Scotland, the Care Inspectorate and Scottish Ministers. For health settings, 'the Act' places a duty on NHS Boards to ensure appropriate numbers of staff and appropriate types of professions. All clinical staff, including staff who provide clinical advice are subject to the duties within 'the Act'.

No.	Board Action
	TSH has been identified as an Early Implementer of the safe staffing template to test out Chapters 5 and 8b of the legislation. Chapter 5 relates to "real time staffing" and risk escalation and Chapter 8b refers to "duty to ensure appropriate staffing". The majority of actions will be implemented this year and in advance for the implementation date of April 2024 • TSH will collaborate with the Chief Nursing Officer, and associated directorates at Scottish Government, on the early implementation process. This will ensure that the duties outlined in 'the Act' are tested, reviewed and safely implemented in advance of April 2024.
1.4	**Mental Health Workforce** TSH has an agreed three-year workforce plan in place. The plan will require further update and review in line with nationally led changes to terms and conditions, e.g. the implementation of the 36 hour working week, protected learning time and Agenda for Change review. There is a Workforce Governance Group in place to manage workforce planning and monitoring. This is aligned to the national workforce planning pillars of: Plan, Attract, Train, Employ, and Nurture. Workforce supply remains a priority area for the organisation. Further workforce information is contained in section C of this plan which outlines delivery of the first year of the Workforce Plan. • TSH will continue to recruit staff up to six months in advance of a vacancy, based on predicted turnover and age retiral. TSH will collaborate through the sponsor team on any national workforce related issues, including terms and conditions changes, and issues associated with alignment to 'the duties' placed on NHS Boards under 'the Act'. • Section C outlines the approach taken by TSH in response to the letter issued by Health Workforce Directorate on 16 May 23.
1.5	**Mental Health Estate** TSH is a relatively new purpose built environment designed for high security mental health care. A major estate refurbishment took place between 2009 and 2011 at a cost of circa £90m. (Appendix B) In the previous two years a number of estates programmes have been initiated to ensure the environment remains optimal. This includes the re-designation of the Family Centre into a dedicated Visitor Centre with outdoor gardens. All Modified Strong Rooms (MSRs) were upgraded in the last year to improve access and visualisation. Modifications associated with the Climate Emergency are noted separately in section 5 of this ADP. • There is a need to develop a planned and preventative maintenance programme for the period 2023/26. This will be developed in quarter 3 and available for review in quarter 4 of 2023/24. • There may be additional site modification proposals required to develop the environment. This would involve creating a more tailored and adapted environment for the sub specialty needs of patients. As funding for this is unlikely to be available through recurring capital allocation, a business case – in the early stages of development – is likely to be required for additional support. This will be considered as part of the capital planning programme, referred to in Section B.
1.6	**Patient Experience**

No.	Board Action
	TSH's public (patients) are with us for an average of 6.5 years, and some very much longer, and therefore are classed as internal stakeholders. It is important that patient experience is tailored based on individualised care, but that the overall experience of the hospital provides a constructive and therapeutic environment to support their recovery and onward progression. Feedback on patient experience is provided regularly to the Board. • TSH will continue to actively engage with patients through the Patient Partnership Group (PPG) and work with patients, carers and families to ensure their individualised and collective needs are reflected in their clinical care. Executive and Non-Executive Directors will continue to attend the PPG to ensure that patient views are heard and acted upon. • TSH will continue to work in collaboration with the independent Patient Advocacy Service, the Mental Welfare Commission for Scotland and external inspectorates using this multi-source feedback to improve on the overall experience for patients in high secure care.
1.8	**Mental Health Equalities** There is a Quality Improvement Framework for Trauma Informed Systems, Organisations and Workforce, expected in summer 2023. TSH has adopted a person–centred trauma informed and formulation driven approach to patient care. This includes focus on the delivery of staff education and support, including Trauma Awareness training which has resulted in 36 members of staff being trained to either Level 1 or Level 2 standard. Additionally, Palliative Care and Dementia training has resulted in 9 members of staff being trained in the delivery of care for a specific subset of our patient population. TSH is actively involved in a cross service working group developing guidance for transgender forensic patients. • TSH will review the forthcoming publication and adapt the current approaches against the framework. A revised plan will be developed in the last quarter of 2023/24 or in line with timeline of the publication.
1.9	**Realistic Medicine** TSH continues to champion Realistic Medicine. There is a local plan covering two years aligned to the six commitments set out by Scottish Government. The Clinical Governance Group and Clinical Governance Committee receive updates on the plan from the Realistic Medicine Clinical Lead. The Executive Sponsorship is through the Medical Director. Further information is contained in section D of this ADP. • TSH submitted an updated action plan to the sponsor team in Quarter 1, a six-month update is required at quarter 3. There may be additional work developed in this area aligned to the Value Based Healthcare approach. Further information is contained in section D of this ADP.

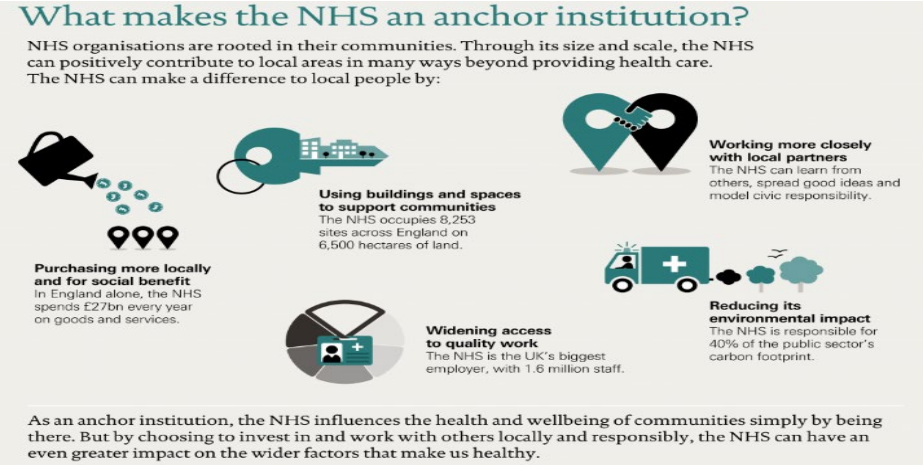
2 Health Inequalities

There are two key aspects to outline with regard of Health Inequalities. The first relates to patient receiving care within TSH. Section 7 of this ADP addresses health inequalities for mental health inpatients at TSH.

Therefore, this section of the ADP will focus firstly on the interface issues between people in custody, and collaboration across health and custody. Secondly, demonstrate a commitment from the organisation in relation to the role TSH can play as an 'anchor institution' supporting the local community.

No.	Board Action
2.1	**Admissions and Transfer for Treatment Directions (TTD)** There is a weekly patient pathway meeting. Patients will be placed on this once accepted whilst the legal processes around their admission are carried out. There is no waiting list for access to high secure care once a referral has been assessed and accepted. Urgent referrals are reviewed within 48 hours (if clinically appropriate) and a transfer arranged as soon as possible thereafter. Admissions are also received directly from court services and other NHS providers. A bi-monthly collated report is provided to the Board outlining admission and transfer numbers and includes any delays. Delays are generally incurred with transferring patients out from high secure to medium secure services in Scotland. Patients subject to a compulsory treatment order, compulsion order, compulsion order with a restriction order, hospital direction or TTD may appeal against their detention in conditions of excessive security to the Mental Health Tribunal for Scotland. The Forensic Network for Scotland issues a weekly bed statement incorporating high, medium and low secure providers. This information is shared with all forensic service providers and the sponsor team in Scottish Government. • TSH will continue to monitor bed usage and report on performance to the Board for oversight and governance. A quarterly report will now be included as part of the sponsorship meeting at each meeting. • Further improvement work within the forensic health system is likely to be led through the 'Collective Leadership Group' once formed. • Short, medium and long-term plans to improve capacity across the Forensic Estate have been developed by the Forensic Network and stakeholder and given to the sponsor team at SGHD.
2.2	**Healthcare in Custody Settings** A Strategic Leadership Group has been formed to enable resolution and improvements in some of the interfaces challenges between health care providers and custody providers across Scotland. There are three sub groups aligned to this process: 1) Consistency: Raising the profile 2) Access to Services: Rules, Regime and Responsibilities 3) Target Operating Models. The current healthcare link on this process is the CEO of TSH. • All actions related to high secure mental health care identified through this process will actioned by TSH. • Collaboration and improvement work in this area will be led directly through Chief Executive Officers, The Forensic Network for Scotland, and the Strategic Leadership Group. This work is active and in progress.
2.3	**Anchor Organisation** The Health Foundation describes an anchor organisation as follows:

No.	Board Action
	'First developed in the US, the term anchor institution refers to large, typically non-profit public sector organisations whose long term sustainability is tied to the wellbeing of the populations they serve. Anchors get their name because they are unlikely to relocate, given their connection to the local population, and have a significant influence on the health and wellbeing of communities'.



SGHD have issued guidance to support NHS Boards develop their Anchors strategic plan, and to outline the support that is currently being developed by Scottish Government and Public Health Scotland to help deliver this important workstream.

TSH is a major employer within Lanarkshire. Approximately 80% of the workforce is from the Clydesdale, Cambuslang, Rutherglen, East Kilbride and Hamilton postcodes. The Workforce Directorate has recently engaged with local higher education establishments around career opportunities within TSH as an employer of choice. TSH will expand this outreach work to other educational establishments as well as local community forums in the coming months in accordance with the Board's agreed Recruitment Strategy.

From a community wealth building perspective, TSH spent 73% of 3rd party spend last financial year with small and medium sized enterprises, with around 89% of that with Scottish SME's including other public bodies.

- A strategic plan outlining TSH contribution to retaining wealth, employment and tackling the determinants of health inequalities will be produced by October 2023. This will build on the recently published guidance. It will be presented to the Board in December 2023, and reviewed by the sponsor team as part of the Quarter 4 performance review cycle. The governance route will be determined as part of the development process and is likely to be through either Staff Governance or Audit Committees
- Monica Merson, Head of Planning and Performance has agreed to be the Anchors Lead for this workstream.

2.4	**EQIA (Equality Impact Assessment)** All policies within TSH are reviewed to assess if a full EQIA is required. Examples of work in this area are: Communications Strategy (EQIA approved January 2022), Pandemic Influenza Communications Strategy (EQIA approved July 2018 and reviewed / updated on 10 May 2023), Media Policy (EQIA approved March 2022), and External Website Maintenance and Development Policy (EQIA approved March 2022).

3 Workforce

TSH developed a Workforce Plan for the period 2022/25. Section C outlines the approach taken by TSH in response to the letter issued by Health Workforce Directorate on 16 May 23.

The plan details the five pillars of workforce planning outlined in the National Workforce Strategy. TSH strives to be an exemplar employer; therefore, the development of a supportive culture that puts staff needs and wellbeing central to delivery is essential. This is reflected in the Staff & Volunteer Wellbeing Strategy and Action Plan. The Workforce Plan will be reviewed and updated in line with nationally led changes to terms and conditions such as the implementation of the 36 hour working week, protected learning time, review of nursing profiles and Agenda for Change review.
The oversight and governance of workforce related Key Performance Indicators is through the Staff Governance Committee.

No.	Board Action
3.1	**e-Rostering Implementation** TSH has commenced the implementation process and roll out of e-roster. Aligned with the national schedule, TSH commenced this work in the last quarter of 2022/23. Preparedness for the introduction of 'the Act' (section 1.2) will include the use of this system and the 'real time staffing template'. This will be introduced in each clinical area. Clinical teams will also work on a self-assessment template. This will enable a Red, Amber, Green (RAG) status for each team which will be monitored and reviewed to provide assurance to the Board. By the end of Quarter 3, TSH will have concluded the testing and implementation phase and embedded e-roster into business as usual. • TSH will update the sponsor team at each quarterly review meeting on the progress with full implementation of the e-roster system.
3.2	**i-Matter, Staff Engagement and Wellbeing** TSH are on target for completion of the iMatter schedule in 2023. The output from this process will be incorporated into the updated Staff Health and Wellbeing Strategy. TSH will continue to tailor staff engagement and feedback events based on the organisational development needs analysis. One of the challenges raised by clinical teams related to getting time off the ward. TSH has introduced a Pastoral and Wellbeing support team which has developed an operating model of ward 'outreach' to support staff in clinical areas, an example of this is the Coffee, Cake and Conversation outreach model which has been developed where wellbeing representatives attend the ward. A calendar of health and wellbeing activities is underway for 2023/24. • TSH will update the sponsor team at Quarter 2 and 4 on the progress of staff engagement and wellbeing activity and the specific targeted approaches taken to address staff feedback.
3.3	**Occupational Health Service** TSH introduced a new Occupational Health Service (OH) provider in Quarter 1 2023/24. NHS Dumfries and Galloway were successful in their submission and were awarded the service through a tender process linked to a service level agreement (SLA).

No.	Board Action
	• A review of the service benefits and progress will be undertaken in Q3 to consider the service 6 months from commencement. • As part the new OH SLA, TSH will increase its provision of Physiotherapy and Health & Safety expertise, employing these roles directly and making a saving from previous SLA. • Introduction of new triage service for staff and managers has commenced and this will be reviewed through the HR & Wellbeing Group and the Workforce Governance Group. • Review of immunisation status' for all staff will be undertaken to ensure that the Board meet their responsibilities as set by the British Standards Institute (BSI). • Full implementation of IT system for appointing and recording health information including recall for appointments. • Development of key policies, for example exclusion and substance misuse. • Introduction of outreach approach by clinicians attending on the hospital site (OH office is currently out with the main site) to build relationships and promote the supportive nature of the service.
3.4	**Recruitment and Retention** TSH is acutely aware of the challenges associated with recruitment and retention. In order to develop the organisations profile, actions to widen the reach for potential new employees have been introduced. These actions include attendance at job fayres, attendance at Higher Education Institutions, recruitment fayres, rebranding of the TSH logo, increased use of social media, dedicated on-boarding support, a recruitment milestones process, and a six-month assessment of likely vacancies from turnover and age retiral. With regard to leavers, TSH have introduced a process on Microsoft forms that all leavers are asked to complete exit interviews in confidence using an easy to access QR code. The results of these questionnaires are shared by HR to the relevant Director for their information and action. The content of the feedback is closely monitored through the Workforce Governance Group. In terms of staff retention, an analysis of data of staff leaving TSH has revealed that we are at higher risk of losing staff within the first three years of their employment. In response to this there has been planned engagement including support, supervision and training for new staff to provide points of connection for staff to raise any issues. The Corporate Management Team have agreed an approach to over recruit at key points in the year to maximise recruitment opportunities. • The Board are reviewing the Recruitment and Retention Strategy to reflect the significant amount of work undertaken so far and are committed to future actions until 2025, aligned with the three year workforce plan. These include, diversifying social media presence, maximising opportunities through the new TSH website to showcase career opportunities, attendance at educational providers to ensure TSH is an employer of choice and specific community outreach using local media etc. • Consideration of apprenticeship placements, other routes to employment for example Annex 21 and ranging 'Employability' options. • The focus on retention has included developing on-boarding surveys, which are issued regularly during the first 12 months of employment for addressing any areas for improvement as well as celebrating success and sharing learning. • Additional areas of developing TSH as an employer of choice include the consideration of Active Travel opportunities, encouraging team development,

No.	Board Action
	flexibility in work patterns and work / life balance, minimising staff moves and enabling staff to achieve positive outcomes with patients through working within the New Clinical Model. • An agreed organisational approach to succession planning and enabling career development through encouragement of personal development review compliance Further information is contained at section C of this plan.
3.5	**Attendance Management** Attendance management is a key priority for TSH as part of the workforce plan. Since May 2022, sickness absence has increased organisationally from 5.09% to 8.27% in April 2023 the reasons for this being stress, anxiety, depression and musculoskeletal problems. Line managers are supported to ensure they are completing quality return to work interviews as soon as possible, training and guidance has been delivered to support this. Reasonable Adjustment guidance has been developed following sessions with the Business Disability Forum to ensure managers are meeting their legal duty to consider this when staff need accommodations to their role, to avoid unnecessary sickness absence. There is a strengthened process in place for temporary placements / assignments to be used for staff who need a short term post to either support their pregnancy or indeed to assist with their return to post from sick leave if there are restrictions in place regarding their phased return. The introduction of the new OH contract allows for triage to a psychologist and a physiotherapist which will continue to be case managed by the Lead OH practitioner to ensure plans are in place for a safe return to work. Joint working between, HR, OH and line managers will encourage more flexibility within the service to accommodate meaningful and supportive phased returns and consider reasonable adjustments to enable safe return to work. Where required this will also ensure there is a plan in place for staff who are absent on long term sickness for redress within appropriate timescales. Introduction of new Assistant HR Advisor role within HR will focus on manager compliance with the stages of the Attendance Management Policy and undertake focused analysis to identify further areas of support going forward. • A “Task and Finish” Group will be established to ensure the focus on supporting Managers and Staff during their absence. This group will consider what we have in place currently and requirements for the future. The group will report to the Workforce Governance Group, Corporate Management Team, and Partnership Forum and provide assurance reporting to the Staff Governance Committee. • Attendance management will be a focus of Directorate Performance Meetings where high absence rates are observed.
3.6	**Organisational Development (OD)** TSH have recognised the requirement for a dedicated full time OD Manager. The OD Manager will commence early June 2023 and key priorities will include the following. • Support for the implementation of the Clinical Model and consideration of OD Interventions. • Focus on the Staff and Volunteers Wellbeing Strategy. • Supporting development of key leadership skills. • Supporting the outputs of the ADP.

No.	Board Action
	• Manage and contribute to key projects to create effective development provision to achieve Board goals. • Close links with the Practice Development Team on areas such as Excellence in Care and consideration of the supporting the Safe Staffing Legislation.

4 Digital Services and Technology

There has been significant focus on developing the organisations digital and e-health function over the last three years. TSH remains fully committed to digital development and enablement.

There have been many benefits from adopting nationally procured systems such as the National Video Conferencing (used for patient and family virtual visits), e-rostering (under implementation), HEPMA (implemented), Microsoft 365 (ongoing), Tableau (implemented) and Near Me (implemented) for health centre consultations.

TSH has invested in a Business Intelligence Team who continue to develop an ambitious suite of dashboards to inform both clinical and managerial decision making. However, there is considerably more that can be done.

In Quarter 2 2023/24 TSH will finalise the Patient Digital Inclusion Options Appraisal. This offers an opportunity to explore the potential, scope, and limitations of Digital Inclusion as it relates to the care of patients. The key driver for this approach is the Digital Health and Care Strategy (Scottish Government and COSLA) which states:

'Our aim is to harness the power of digital services and technology within our healthcare services continues with the publications of Care in the Digital Age, Delivery Plan 2022-23, with a 2023-24 Plan following in April.'

Other national programme deliverables relevant to TSH Patient Digital Inclusion ambitions include:

- the expansion of the use of Near Me for group treatment programmes in mental health and educational type interventions
- access to digital mental health therapies
- implementation of the 'Digital Front Door' to support access to health and social care services

Naturally, the national programme deliverables are focused on citizens across Scotland. However, TSH continues to focus efforts on the needs of patients in mental health settings, in particular in high secure care.

TSH ambitions are particularly informed by the reports 'Supporting Communication and Technology Use in Mental Health Settings (2018 and updated in 2021): Communications and Technology Short Life Working Group (School of Forensic Mental Health and NHS Scotland Forensic Network). These two reports provide a detailed literature review, insights into patients and their carer's experience of digital inclusion and a compelling case for change. Importantly, the reports highlight what is possible referring to the progress made in low and medium secure services in England. It makes a recommendation to Scottish Government to form a National IT group to provide a forum to:

- enable service representatives to stay up to date with new security risks from IT and communication devices
- consider the application of relevant legislation
- develop policy and guidance to ensure a consistent approach to technology use
- influence and support the integration of eHealth within secure services

- promote consistency and standardisation in the use of hardware/software across the estate
- link with National initiatives which may provide assistance to services (e.g. Connecting Scotland)
- define support required for patients to enable them to develop digital skills and knowledge of how to use the internet safely
- review staff training needs and develop proposals to address these

The Working Group's 2018 report suggested stratified levels of access, which for High Secure were:

- no personal devices
- access to safe email
- access to hosted digital service, restricted content for subscribers via a 'walled garden', and approved white site list on hospital devices
- controlled service access to Video Conference
- games consoles (not WI-FI enabled)

The 2018 and 2021 reports remain with the Scottish Government for a response.

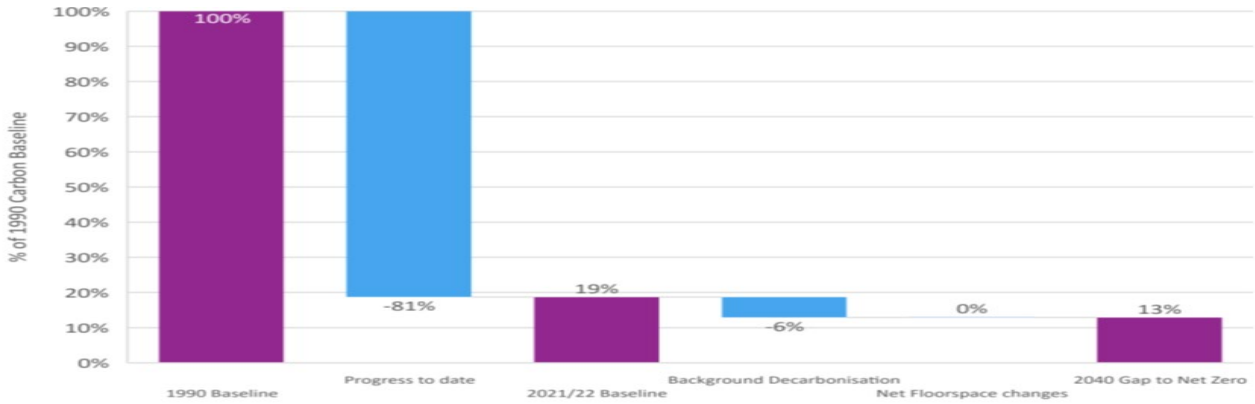
No.	Board Action
4.1	**Patient Digital Inclusion** In Quarter 3 2023/24 TSH will have produced the Patient Digital Inclusion Options Appraisal. This report offers an opportunity to explore the potential, scope, and limitations of Digital Inclusion as it relates to the care of our patients. • Aim to have the report approved, in principle, through the Board in Quarter 3 of 2023. Review with sponsor team colleagues and try to encourage a decision on the inter-related 2018 and 2021 reports. The outcome can them be incorporated into the MTP. Discuss with sponsor team at Quarter 3.
4.2	**TSH WIFI Network Upgrade** In order to fully support digital innovation, there is a requirement to upgrade and expand the hospitals WIFI network. A business case will be developed and a capital request submission in 2023/24. This will secure the network capacity to fully take forward the Patient Digital Inclusion appraisal outcome. • A capital submission will be made to secure funding for the WIFI network in 2023/24.
4.3	**Scottish Health Competent Authority – Network and Information Systems (NIS) Regulation Audit** TSH have undertaken considerable work in relation to cyber security and the requirement associated with NIS. The organisation will participate in the NIS Regulation Audit process in 2023/24. The dates for the audit process are: – Onsite Audit: 05 June – Submission Deadline: 16 October – Staff Meetings: 22 November – Interim Report: 27 November – Management Meeting: 06 December – Final Report: 11 December • There is an active working group overseeing the action points relevant to NIS compliance.

No.	Board Action
4.4	**Optimising M365** Licencing for M365 is tightly managed by the e-health team within the TSH site. TSH is unable to take advantage of the M365 resource at present. There remains concern nationally around governance and back up and resolution is being sought. This issue is not preventing us from identifying our requirements and progressing with the design and layout of the new SharePoint site. TSH will use SharePoint to redevelop the intranet site. The project is at an early stage pending resources, governance approval and other necessary requirements. • Due to the current issues, it is difficult to provide and exact timeframe. However, the process overall is likely to take around 12-18 months.
4.5	**Digital Maturity Exercise** TSH are currently assessing our digital maturity as part of the Scottish Government / COSLA Health and Social Care Digital exercise. This provides guidance and questions enabling us to look at where we currently are and what changes are still required to achieve this. Digital maturity is not just about the systems and technology we use every day - it is about how we, as an organisation, use these systems to support and develop our staff, and to develop our skills and understanding in the digital workspace. Our digital maturity is embedded in our strategy and will be key to delivering this successfully. It is a gradual process of integration and implementation of organisational developments, beginning with our digital inclusion options appraisal in 2023/24 - and timetabled to be realised through this process. This will require investment in the tools and resources that can best leverage technology, and while these are pressured in the present financial climate, we are on track with the technology and systems presently in place.
4.6	**General Data Protection Regulation (GDPR)** TSH was inspected by the Information Commissioners Office in December 2022. The inspection reviewed Governance and Accountability, and Data Sharing. The organisation received an assurance rating of ‘high’.

5 Climate Emergency and Environment

TSH recognises the role it plays in NHS Scotland’s approach to the climate emergency as set out in DL (2021) 38. The organisation has achieved its 2030 target of a 75% reduction from a 1990 baseline target.

There is considerable opportunity for TSH to reach the NET Zero target by 2040.



No.	Board Action
5.1	NHS National Services Scotland procured a 'Once for Scotland' approach to provide analysis for all NHS Boards carbon management. TSH is awaiting the formal report from Jacobs (an external carbon management organisation) in order for further plan actions in support of decarbonisation. The report has been received in draft in late May and will be finalised by late June. Following finalisation of the report, the actions will be incorporated into the planning cycle and work stream of the TSH Climate Change and Sustainability Group. • Further milestones will be developed once the external report is received and reviewed by the Sustainability Group Decarbonisation fleet: TSH have a relativity small fleet of vehicles, which consists of seven light commercial and two heavy vehicles. Of the seven light commercial vehicles two are electric, with the remaining five powered by fossil fuel. The Procurement Department are actively involved with assessing the most advantageous route for the replacement of four of these vehicles to further decarbonise the fleet. The two heavy vehicles are tractors used for site maintenance. • TSH are currently developing a Transport Strategy that will include how the TSH Board will meet the 2025 targets for car/light commercial vehicles and 2032 target for heavy vehicles to decarbonise the fleet.
5.2	TSH have achieved the waste target in DL 2021 (38). As a Board, TSH continue to follow the waste hierarchy where practicable to continue to reduce emissions. When waste is created, the top priority is waste prevention, then reduction, recycling, recovery through energy from waste methods and finally disposal via landfill as the least preferred method.
5.3	Decarbonising heat will be the biggest challenge for the site to reach Net Zero. Improvements to building fabric and the heating network have helped to reduce thermal demand, therefore any further reduction in emissions will need to focus on generation assets. While the biomass boiler was installed in 2009, the LPG (Liquefied Petroleum Gas) boilers were only installed in 2017. If the site wishes to maximise the economic output of their assets, it is likely that the use of fossil fuels will continue for quite a number of years. Additional challenges include the high security nature of the site which mean that the design specification of the site meets standards that may not be required by any other Health Board in Scotland.

No.	Board Action
	Potential future use of green hydrogen in place of LPG being developed. This would not require major changes on site e.g. utilise existing tanks (installed in 2017) and burner head replacement required. Such systems could potentially utilise the existing low temperature heat networks only requiring a change out of generation assets. There is considerable space on site for both horizontal and vertical bore holes. An assessment of the geomorphology of the site is required to verify this. A backup system will still be required to provide redundancy for the site. That will most likely need to be a fluid fuel which can be stored onsite. Both bio-LPG and HVO (Hydro-treated Vegetable Oil) would be the most likely option, though as the biofuel market develops and grows, other options may become more viable. There is considerable space available for both solar and wind generation. TSH Climate Change and Sustainability Group will review actions associated with the potential development of renewable energy using these sources. The following actions will be taken forward to support decarbonisation in 2023/24. • LED (light-emitting diode) lighting for grounds has been purchased and due to be installed over the summer period. • Electric vehicles (EV) charging points: awaiting final commissioning certificates. KWH (kilowatt hour) charging rates to be determined, likely to be similar to existing electricity charges plus small amount to cover maintenance costs. TSH will provide advice on usage (not enforceable). • Bid submitted to 'switched on fleets' for further six external charging points, outcome expected in summer 2023. • Bid due to be submitted to the Scottish Central Government Energy Efficiency Grant Scheme for internal LED lighting by end Q1. Outcome expected in Q2, with spend by end 23/24.
5.4	NHS Scotland have introduced a new NHS Scotland Environmental Management System (EMS) provided by RiO in June 2021. Individuals at TSH have been given the relevant access rights and training for the system, and have commenced with the population of the EMS for the Board. • Reporting on the EMS is through the TSH Climate Change and Sustainability Group and is further reported into the Board and Scottish Government.
5.5	The geographic location of the site results in periodic extreme, sub-zero winter conditions, which are occurring with increasing frequency. Such weather events may prove to be a challenge for some low carbon heat technologies currently available in the market and may limit the opportunities available to the site. Furthermore, the rural location of TSH limits the opportunity of district heating systems. A climate change risk assessment has been completed in 2022/23. • The Climate Change Adaption Plan will be developed following the risk assessment to ensure resilience of service under changing climate conditions will be completed for Q4.
5.6	TSH has mapped the estate and has developed a biodiversity report in collaboration with other National NHS Boards.
5.7	TSH current patients are cared for in purpose built buildings with single occupancy bedrooms. There is no additional requirement for specialised ventilation systems.

No.	Board Action

6 Security

The purpose of security in psychiatric care is to provide a safe and secure environment for patients, staff, volunteers and visitors which facilitates appropriate treatment for patients and protects the wider public.

All patients in TSH have been assessed as requiring high security care. As such, all areas within TSH are maintained at a level to meet the criteria set by the high security matrix.

The specific features of high security are categorised into three domains: physical, procedural, and relational. In addition to the measures in place across the site, all patients are subject to a range of security measures tailored to their clinical and risk evaluation needs and the stage of their treatment journey.

No.	Board Action
6.1	**TSH will complete the Perimeter Security and Enhanced Internal Systems Project in this current year.** • Complete the overall project in the current year, and as soon as practicably possible. • Develop and implement an underpinning framework for the security systems and clinical security to support the Clinical Model (currently under implementation)

7 Patient Physical Health

People with major mental illness and intellectual disabilities are at greater risk of poor physical health and premature mortality. Health inequalities for the patient population within TSH are extensive and major area of organisation focus.

From a 20 year follow up of former patients in TSH, it is known that this patient cohort died approximately 16 years earlier than the general population as a whole (Rees and Thomson, 2021). This is largely due to preventable physical health problems.

Within the wider forensic population (and for those who experience severe mental illness) the presence of persistent physical symptoms is higher than that of the general population. Individuals with severe mental illness experience higher rates of mortality and morbidity from cardiovascular diseases, respiratory diseases, genitourinary causes, digestive diseases, diabetes, and cancer (John et al, 2018).

In order to reduce this health inequality, it is crucial the patients are supported and encouraged to address their physical health needs.

The work of the Physical Health Steering Group and Supporting Healthy Choices Group focuses predominately on improving physical health outcomes. An action plan is in place. This is supplemented by a newly introduced Activity Oversight Group (August 2022) to actively monitor the amount of time patients spend on both physical and meaningful activity. The group meets monthly to review activity data and have taken a Quality Improvement (QI) approach. Nurse Practice Development also provide support for staff to develop nursing care plans with a focus on physical health monitoring for patients.

In October 2022 a full time health psychologist was recruited at TSH, adding to the commitment to improve the physical health of patients. The health psychology role aims to support patients to improve physical health and wellbeing through psychologically informed health care; indirectly through work with staff and also by delivering direct health psychological care to patients.

TSH has several Key Performance Indicator's (KPI) to provide assurance on patient physical health. These are:

- patients will be offered an annual physical health review: Target 90%
- patients will be engaged in off hub activity: Target 90%
- patients will be undertake 150 minutes of exercise each week: Target 60%
- patients will have a Healthy BMI: Target 25%
- performance against target is monitored monthly and reported to the Board quarterly

The KPI's are reviewed annually to ensure they are contemporary. The off hub activity centre's KPI will be redeveloped in 2023/24 to reflect changes on the clinical model and improvements in TSH ability to track individual patient activity.

No.	Board Action
7.1	**Physical Health Needs** Physical health and supporting healthy choices is a key priority of TSH. It is of equal importance and priority to mental health support needs within the organisation. The key priority is to incrementally improve the physical health of patients, educate on the determinants of ill health and lifestyle choices. • An update will be provided in Quarters 2 and 4 in relation to progress and delivery of this key ambition.
7.2	**Physical Health Support** TSH has a bespoke service for physical health support, including an onsite health centre incorporating a dental suite. Regular GP services are provided through a SLA with a local GP. Full primary care facilities are available, annual health checks undertaken and screening programmes are carried out. • TSH will continue to undertake annual health checks on all patients, including screening programmes for eligible patients. The KPI's are reported to the Clinical Governance Committee.
7.3	**Psychologically informed physical health care** The aim is to lead in fostering an environment which uses available evidence while also taking account of competing demands so that patients and staff are supported and enabled to promote good physical health at every available opportunity and intervention.
7.4	**Indirect interventions for physical health** The health psychologist will assist patients with their physical health indirectly through providing support to the staff that they work with across the hospital. This includes a number of activities and interventions that aim to enable staff to effectively support their patients with psychological and emotional aspects of physical health. This includes teaching and training, consultation and coaching/supervision.

7.5	**Direct Psychological Interventions** The health psychologist will carry a small individual caseload and will provide input to different areas of the weight management pathway by developing a robust, interlinked range of psychologically informed interventions to be delivered by multi-disciplinary professionals.

8 Patient Pathways

No.	Board Action
8.1	**Clinical Model** The Clinical Model describes how clinical care is structured and delivered at TSH. With a focus on providing tailored and individualised approaches to delivery of mental health care, work on the Clinical Model was paused during Covid and has since restarted in 2022. TSH Board approved a Project Initiation Document in June 2022 to progress with the project. The Clinical Model had been developed to provide an enhanced treatment environment with a focus on recovery. There are four sub specialties within the model: 1) Admission and Assessment 2) Treatment and Recovery 3) Transitions 4) Intellectual Disability. • The project implementation will be completed by end Q1 with stand up of the four clinical sub speciality services expected by end Q2. Ongoing monitoring of the clinical guidance will take place throughout the year to assess the effectiveness of the model both in terms of patient and staff satisfaction and in terms of risk management. • An external evaluation has been commissioned to assess the project outcomes and impacts against its stated objective.
8.2	**Scottish Patient Safety Programme** In response to the Scottish Patient Safety Programme national framework 'From Observation to Intervention: A proactive, responsive and personalised care and treatment framework for acutely unwell people in mental health care' published in 2019 TSH has developed and consulted on a new Clinical Care policy. This is a way of caring for patients to meet their individual needs based on immediate identified risks. • In 2023/24 an implementation plan will be developed to support the rollout of the policy over Q2 4 using Quality Improvement methodology. It is expected that this new way of working will result in further minor revisions to the policy to ensure it is fit for purpose across each of the service areas (i.e. Admissions, Treatment and Recovery, Transitions, and Intellectual Disabilities).
8.3	**Visitor Experience** The Family Centre was redeveloped and upgraded in to a central Visiting Centre in 2022/23. An evaluation process of visitor experience will take place in quarter 3 of this year. This will include engagement with carers and families.

No.	Board Action
8.4	**Daytime Confinement** As part of the restrictions required to keep patients safe during the Covid pandemic, a change to clinical practice for infection prevention and control purposes was introduced. This approach was to isolate patients in their rooms, however this is not considered clinically acceptable in normal practice. It also runs the risk of being considered as an element of Type 2 seclusion when the patient has not activity chosen this. Due to national recruitment challenges, this approach continues to be utilised at times. Reducing the use of 'daytime confinement' to a never event is an organisational priority for 2023/24. Action A short life working group will be established in Q1 with an aim to have ensured a sustainable model is in place to prevent 'daytime confinement' as much as possible by Q4

SECTION B: FINANCE AND SUSTAINABILITY

The draft base budgets have been established, with forecasts provided to Scottish Government for 2023/24, 20242/25 and 2025/26. The baseline for the three-year period shows a small overspend (approx. 1%) in 2023/24 – arising from the key risks and pressures noted below.

While it is anticipated that the energy cost pressures may diminish beyond 2023/24 into the next period, the pressures from essential additional staff posts will continue on a permanent basis. This could also be subject to change once there is notification of 2023/24 pay circulars from Scottish Government.

Key risks for the forthcoming period have been identified as:

- energy costs (potential £550k increase)
- additional essential operational posts required (potential £300k)
- costs of enhancing and strengthening essential digital innovation and inclusion (£ tbc)

Other pressures highlighted are:

- Workforce Plan Numbers and Skill mix - due in part to the fall in staff turnover, it has not yet been fully possible to achieve the planned workforce. The issues relate mainly to nursing costs. The full workforce plan aligned to the clinical service delivery model and safe staffing legislation is under review, to link with the review of the Clinical Model.
- Pressure from any unfunded element of increased payroll costs that are not met centrally
- Payroll impact continuing from the 2019 outcome of the legal case “Locke vs British Gas” and the potential liability for additional shift payments required
- Potential increases in rates
- A number of costs associated with the hospital estate upkeep / backlog maintenance programme, all monitored closely and outturns adjusted accordingly. Ongoing evaluation of this impact over the coming years is assessed for budgetary pressures to be controlled
- The requirement for the National Boards to provide additional savings of £15m on a recurring basis in 2023/24 and beyond
- A savings plan around the workforce, capital charges and supplies may need to be extended if the on-going costs of the new Clinical Model (currently at the implementation stage) are more than forecast
- Also year on year, it gets harder to identify workforce savings without affecting patient care or security. The staffing costs for TSH are 84% of the total revenue budget. If plans fall behind the financial balance could be at risk unless other non-pay savings can be found
- The lack of any increase in capital funding potentially leaves equipment replacement at risk, as the allocation will require close control and review to be able to cover any major equipment replacement programmes

The capital resource budget has been set with agreed priorities for 2023/24, from discussion through the hospital’s Capital Group and Corporate Management Team and is expected to be fully utilised. We are now also looking at capital demands for 2024/25 and beyond. The allocation for 2022/23 was fully utilised, including additional priority funding agreed specifically regarding security work required on the MSRs and the Hospital’s main key safes, and other essential approved spending as part of the national support for backlog maintenance work.

SECTION C: WORKFORCE

TSH Workforce Plan for the period 2022 – 2025 details the Five Pillars of Workforce Planning outlined within the National Workforce Strategy, these are:

1) Plan
2) Attract
3) Train
4) Employ
5) Nurture

The National Strategy details that these should be the basis for action to secure sufficient workforce to meet both short term recovery and medium term growth and transformation in our services and workforce. Therefore, detailed below is progress towards actions achieved in year 1 2022/23 of the plan and outlines proposed work within each of the areas.

1) Attract

TSH have developed a Recruitment Strategy and Action Plan in June 2022 to meet the organisational objectives of recruiting and retaining an effective and modern workforce. The purpose is to ensure that we recruit the right people, in the right place at the right time. This strategy is not only aimed at attracting new / returning staff but also those who are under schemes developed to provide routes to employment. A Short Life Working Group has been established to update this Strategy with an additional emphasis on retention and marketing TSH as a great place to work. This is due to be approved in June 2023.

In order to develop the organisations profile, actions to widen the reach for potential new employees have been introduced.

These actions include:

- Attendance at job fayres
- Rebranding of the logo / brand for TSH
- Increased use of social media

Further local work is required to analyse positive response rates for roles, where we are attracting candidates from and maximising good practice. For example the table below demonstrates the top ten places where candidates who applied for roles, discovered our adverts

Advert Source	Candidates who applied Count	Advert Source	Candidates who applied Count
Indeed	422	LinkedIn	103
NHS Scotland Website	320	NHS Intranet	91
Candidate did not disclose	281	Google	59
Word of mouth	125	Other	51
NHS Internal Job	112	Facebook	47

Using Social Media within TSH is in its infancy however we will continue to monitor its usage to ensure we are utilising this as widely as possible. Analysis of data has revealed that TSH has run a similar number of recruitment adverts in 22/23 compared to 21/22.

Year	No of Adverts/Campaigns	No of Posts to be Filled
20/21	53	77
21/22	92	164
22/23	89	153

TSH has also prioritised retention of staff within the strategy and will continue to develop this strand of work in 2023/24. Current progress has been the development of the on-boarding process and induction programme for all new employees. All members of staff who have either change roles or are new to the Board will be contacted at three, six and twelve months to check in on their experiences to date.

With regard to leavers, TSH have introduced a process on MS forms that all leavers are asked to complete exit interviews in confidence using an easy to access QR code. This has proven successful where the levels of input has increased and those leaving the organisation making contact to give their feedback.

Anchor Organisation
As an Anchor Organisation TSH aims to be an employer of choice and is reflective of the Community. This will form part of our Recruitment & Retention Action Plan, ensuring that we maximise local opportunities.

This includes consideration of the following:

- Location
- Transport Links
- Links with Schools and HEI to look at opportunities for development of future staffing

2) Train

TSH has a strong focus on staff wellbeing, career development, and adhering to staff governance standards to maintain a skilled and motivated workforce that feels valued and is equipped to deliver high quality services and care. TSH is committed to supporting the training and ongoing development of all staff, and a key component of this plan is the provision of education and learning to help train and develop staff at all stages of their employment.

Nurse Practice Development
The Nurse Practice Development Team lead a number of key projects, working closely with organisational development, learning, training and development and the education and development of nursing staff within TSH. These projects are ongoing from 2022/23 into 2023/24 and include:

- Following recent consultation, embed the new clinical care policy into practice and ensure its alignment with the revised clinical model structure.
- Continue to work with colleagues from NHS Education Scotland to undertake a pathfinding project to explore and develop a framework for the delivery of a sustainable model for the delivery of nursing clinical supervision.
- Development of a peer support network that will consist of both clinical and non-clinical peer support workers throughout the organisation. Since the start of 2023 there have been three separate training sessions delivered, with a total of 18 staff now trained as peer support workers. There is a further training date scheduled for June.
- Development of specialist dementia training skill with delivery to 26 nursing staff and seven multidisciplinary team members over six bespoke sessions, and trained nine nursing staff with palliative care and dementia.
- Review the current nursing induction process (including secondary induction) with the dual aim of streamlining processes whilst also increasing the number of inductions carried out each year
- Work to increase delivery of nursing assessment and care planning.

Corporate Training Plan
TSH delivers on a broad range of training and development activities through the annual Corporate Training Plan. This includes a focus on:

- Core statutory and mandatory training - including training on fire safety, health and safety, infection control, information governance, PMVA, equality diversity and rights, safeguarding, security, suicide awareness and prevention, and workplace first aid.
- Clinical practice - including training on autism, epilepsy, food, fluid and nutrition, intellectual disability, physical health and health improvement, relational approaches to care, Talking Mats, and trauma informed care.
- Leadership and management development - with an emphasis on coaching, leadership skills, management essentials and people management skills.
- Practice development - including training relating to clinical supervision, excellence in care, improving observation practice, key worker development, Flying Start and New to Forensics.
- Psychological Therapies - including training on CBT for psychosis, low intensity psychological therapy, life minus violence therapy, MBT, personality disorder risk assessment, positive behaviour support, trauma & PTSD, violence risk assessment and management, and external supervision for staff delivering psychological therapy programmes.
- Quality Improvement - including training on feedback & complaints, QI essentials and realistic medicine.
- Records management and data protection training – including DPIA training, and training on effective records management and record keeping.
- Risk and resilience - including incident command training, comms officer training, ‘Golden Hour’ training, and multi-agency incident response training.
- Technology and digital skills - including training to support the implementation and rollout of eRostering, and training on key IT systems including Datix, eESS manager and employee self-service, HEPMA, Tableau dashboard and RiO.
- Workplace wellbeing - including training on leadership for mentally healthy workplaces, mental health first aid, psychological safety, and peer support training.
- Whistleblowing - with a focus on ongoing roll-out of the INWO Whistleblowing Standards online training programme.
- Bursary scheme - to support staff undertaking further education.

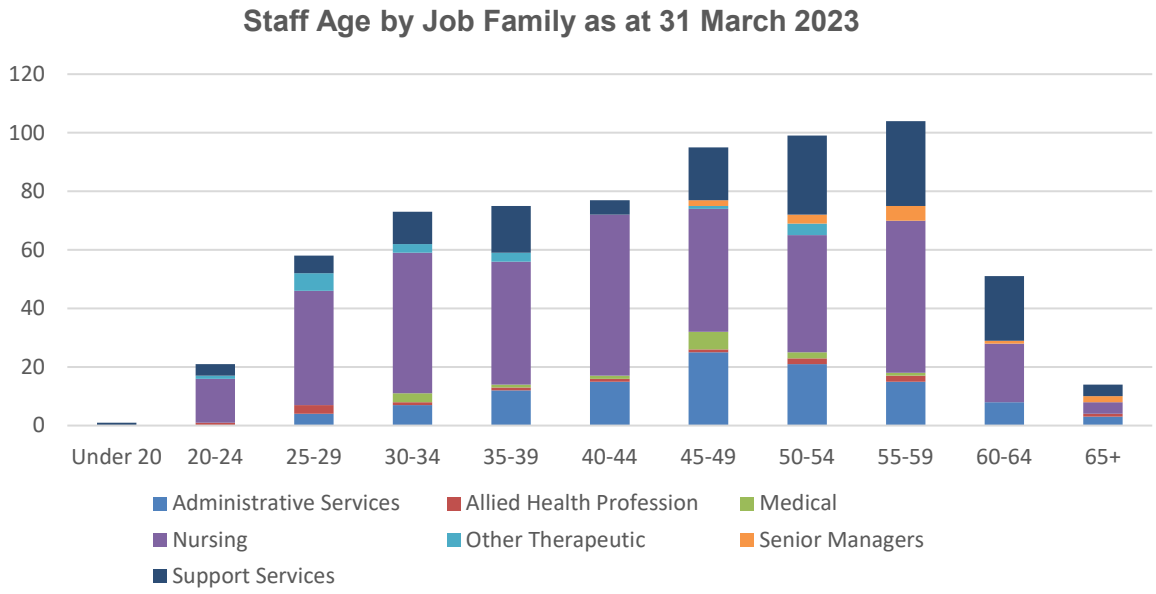
A total of £81,308 has been allocated from the Corporate Training Budget to support delivery of corporate training for 2023/24.

In 2022/23 TSH achieved its targets for both statutory and mandatory training, 94.2% compliance for statutory training and 85.9% compliance for mandatory training against an 80% target. The compliance rates have been progressing in an upwards trajectory since September 2021.

3) Employ

Staff are TSH greatest asset and resource, 84% of TSH budget is committed to staff costs. Delivery of high quality care is dependent on recruiting a workforce who are skilled and retaining their skills to ensure we meet patient care needs.

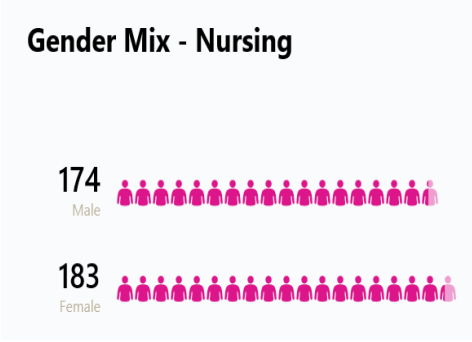
The chart below demonstrates the age range of TSH employees and associated job families.

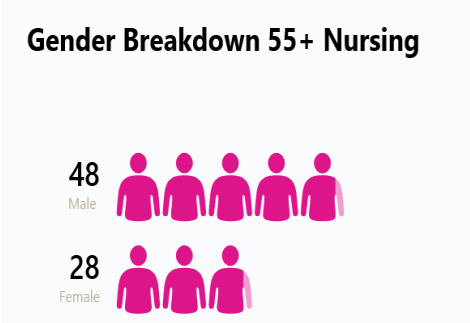


There is a slight reduction in all staff numbers in the 50 to 65+ category by ten and an increase in the age under 20 to 49.

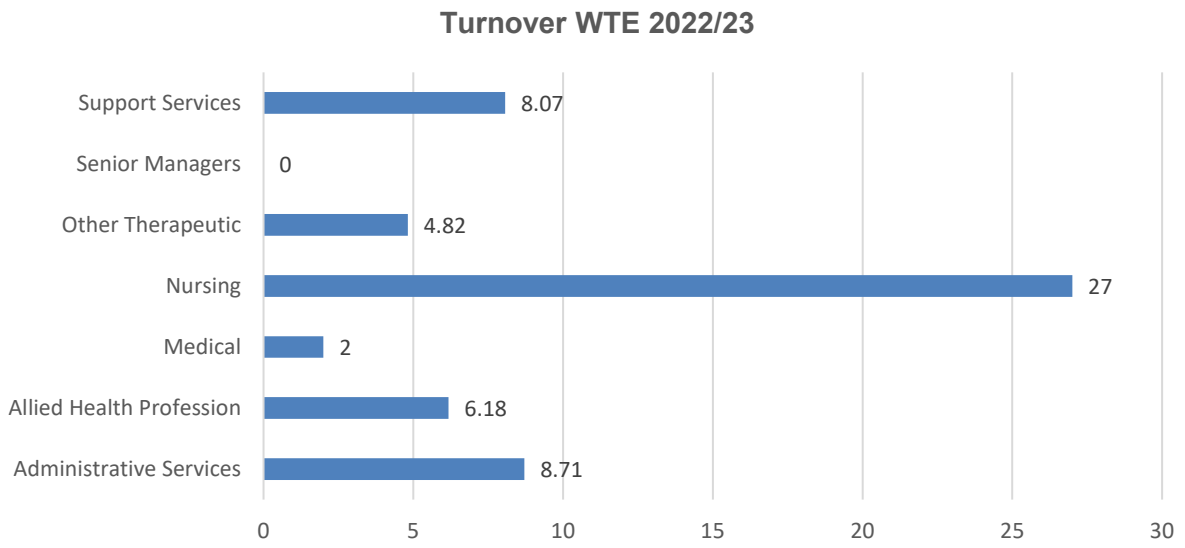
Within the Nursing staff group, we are seeing higher levels of staff returning to join the Supplementary Staffing Register once retiring. The number of 50+ employees has reduced by 14 and we are seeing an increase in staffing under 49.

Gender Mix
Gender mix in nursing staff is a consideration in resource allocation. Current gender distribution for nursing staff is below for information.





Turnover
Turnover in 2022/23 was 70 staff, 56.78 WTE. For Nursing there was 31 leavers, 27 WTE. Work continues on the area of retention within our updated Recruitment & Retention Strategy.



Recruitment
It is essential that TSH support staff through the employment process. This ensures a welcoming introduction to TSH and provides a consistent and robust process. In 2022/23 a series of KPI's were developed to track the performance of the recruitment process. These are reported monthly to the Workforce Governance Group. TSH also fully embraced Job Train as the platform for recruitment, ensuring that each manager now utilises this platform to fill vacancies.

Key vacancies have been secured in year. TSH has stabilised its infection control resource through the recruitment to the role of the Infection Control Facilitator. This resource will be embedded permanently into organisation's resilience approach. Proactive recruitment has also taken place in roles where there is a known turn over. Challenges continue to exist in filling Nursing Band 5 vacancies and TSH have reviewed skill mix of teams to balance potential shortfalls.

TSH is committed to developing apprenticeship programmes to assist in balancing our ageing workforce and help attract more staff into a career within the NHS. There is one Modern apprentice currently in post in the organisation. There is commitment to providing two modern apprenticeship placements within nursing per year, and opportunities for future expansion of apprenticeship programmes within the organisation will be actively explored.

4) Nurture

TSH is committed to providing a healthy working environment which promotes and protects the physical and mental wellbeing of its employees. A tiered support model has been adopted based on the principles of Psychological First Aid (i.e. Care, Protect, Comfort, Support, Provide, Connect, and Educate).

Our workforce is the most valuable asset and therefore we will continue to ensure that individuals are fully supported in the pivotal roles of maintaining safety and security whilst delivering front line care to patients in sometimes challenging and complex circumstances. A permanent Wellbeing Centre has been in place since October 2020. This provides a space for both Staff and Volunteers to relax and recuperate.

Support offered over 2022/23 includes:

- Programmed targeted information sessions e.g. women and men's health weeks, activity challenges which engaged over 50 staff members, credit union, creative writing and outreach 'Coffee, Cake and Conversation' which engaged 123 staff over 9 events.
- Support for all Staff and Volunteers to access the Wellbeing Centre for specific wellbeing events e.g. workplace massage therapy.

- Direct peer support with 16 staff trained in 2023.
- Pastoral support via Staff Care Specialist, information events, signposting, listening spaces or coaching. Pastoral care have provided support for 56 referrals.
- Provision of targeted interventions linked to existing priority work streams (e.g. trauma informed care and psychological safety) specifically aimed at enhancing line manager capability in relation to Staff wellbeing and support. e.g. 20 managers have been trained in Supporting a Mentally Healthy Workplace

A three-year Staff & Volunteer Wellbeing Strategy and Action Plan has also been developed and approved at the Board in April 2022. This Strategy is for all Staff, Volunteers and any colleagues who work for TSH. The Strategy focuses its efforts in eight areas: mental health, environmental, financial, personal growth and development, physical health, social, spiritual and occupational. It encompasses the work of Healthy Working Lives as well as any wellbeing work across the organisation.

The Strategy and Action Plan will undergo scrutiny through evaluation using local data, set KPI's and feedback from stakeholders.

Over the course of the next three years, implementation will involve ensuring support at the following levels:

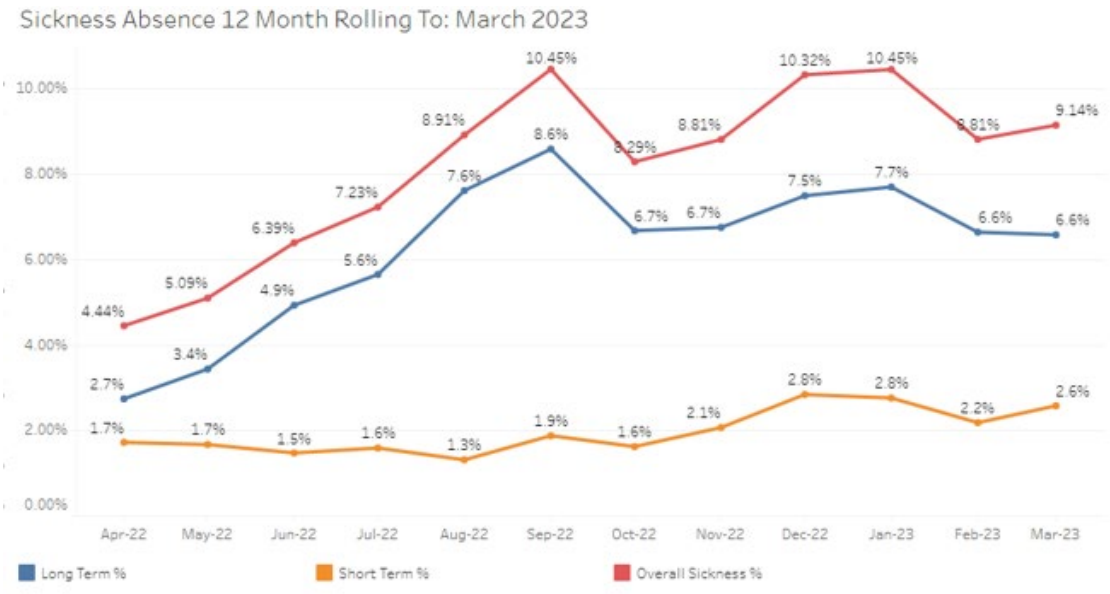
- Self-help, providing resources and signposting staff.
- Peer, offering advice and opportunities for staff to access one-to-one or group support.
- Line management, ensuring appropriate training opportunities are available for our managers.
- Organisational, making the links with the relevant organisational and national groups to ensure our approach is inclusive, comprehensive and encompassing.

TSH will continue to encourage feedback through iMatter questionnaires and the completion of Action Plans by each Team. "What Matters to you" was carried out in 2022/23 and will continue to be asked on an annual basis to ascertain what additional supports can be put in place for all staff and volunteers.

The SPSO (Scottish Public Services Ombudsman) developed a model procedure for handling whistleblowing concerns raised by staff and others delivering NHS services and this was formally published on 1 April 2021. The Independent National Whistleblowing Office (INWO) provides a mechanism for external review of how a Health Board, primary care or independent provider has handled a whistleblowing case. For NHS Scotland staff, these form a 'Once for Scotland' approach to Whistleblowing. As part of the Whistleblowing Standard, a quarterly update is provided to the Board on the current situation with any outstanding Whistleblowing Investigations. An Annual Report is also produced and a copy is also sent to the INWO for their information.

Attendance Management
Attendance management continue to be challenge within TSH. The figures below demonstrate an upward trend, with 2022/23 saw an overall increase in our Sickness Absence

Sickness Absence



Nursing Staff

Sickness Absence for Nursing Staff has also increased and work will continue on improving the support to all nursing staff with an overall 2% reduction request during Performance Reviews on a quarterly basis.

Actions for 2023/24 include:

- A Task and Finish Group has been established to develop and action plan to support absence management.
- TSH have engaged a new Occupational Health Service, which will support staff health and on return to work.

SECTION D: VALUE BASED HEALTH AND CARE

Realistic Medicine (RM) is the Scottish Government's approach to delivering Value Based Health and Care (VBH&C) in Scotland. VBH&C is defined as "the delivery of better outcomes and experiences for the people we care for through the equitable, sustainable, appropriate and transparent use of available resources". VBH&C is based on the primary principle of person-centred care - care that is not only high in quality but also delivers the outcomes and experiences that really matter to people, defined by and reported by them. In addition, VBH&C seeks to reduce the waste, harm and unwarranted variation that exist across our health and care system. The equitable distribution of resources is key to delivering VBH&C. It is by practising RM that we will deliver VBH&C

TSH continue to champion RM, and Value Based Health & Care. The TSH RM action plan for 2023/24 was submitted to Scottish Government in May 2023. It demonstrates the commitment of the organisation to delivering VBH&C via the RM principles and provides the mechanism through which progress towards this aim is measured and monitored. The action plan has a renewed focus on specific projects relevant to the RM principles. Each project has also been aligned with the relevant VBH&C commitment from the Scottish Government's VBH&C action plan – set out below:

1) Continue to promote RM as the way to deliver Value Based Health & Care.
2) Promote the measurement of outcomes that matter to the people we care for and explore how we can ensure a coordinated approach to their development and implementation.
3) Continue to support the development of tools that enable health and care colleagues to seek out and eliminate unwarranted variation in access to healthcare, treatment, and outcomes.
4) Continue to build a community of practice and a culture of stewardship across Scotland.
5) Support delivery of sustainable care in line with the NHS Scotland climate emergency and sustainability strategy by reducing waste and harm.
6) Continue to engage with the public to promote understanding of RM and VBH&C and its benefits for Scotland. We will also work to empower people to be equal partners in their care, through shared decision making enabling self-management, and promoting health literacy and healthy lifestyle choices.

TSH action plan builds on these commitments and sets out the action we will take to deliver on them. It is hoped this provides a more accessible and meaningful plan for the staff of TSH and the wider group of stakeholders who will access it.

SECTION E: INTEGRATION

Through the National Directors of Planning Group TSH is supporting and participating in an integrated approach to recovery and delivery planning across NHS Scotland. We will share the content and focus of our annual and medium term plans as a collective group of national Boards, with the intention of identifying any key activities or projects that would benefit from wider collaboration.

The ADP and MTP will be circulated to the following stakeholders in advance of completion for feedback. They will also receive final versions.

- NHS Greater Glasgow and Clyde Forensic Services Manager
- NHS Lothian Planning Manager
- NHS Lanarkshire Planning Manager
- Patient Advocacy Service
- Mental Welfare Commission
- Scottish Government Sponsor Team
- Forensic Network, Scotland
- Internal Stakeholder Session
- PPG will receive a presentation on the plan

SECTION F: OTHER PROGRAMMES

Resilience, Risk and Business Continuity

TSH, although not a Category 1 or 2 Responder, awaits the outcome of the 'Preparing for Emergencies Guidance Review' and will work with SGHD colleagues to ensure compliance where appropriate.

Level 3 Plans

TSH level 3 plans are those of a multi-agency joint working model. These plans involve input from partner agencies, Police Scotland, Scottish Fire and Rescue, Scottish Ambulance Service, South Lanarkshire Council and the West of Scotland Regional Resilience Partnership. Work continues to develop and refresh Level 3 plans to a standardised format in line with those of our partners.

The Multi-Agency Incident Response Guide (MAIRG) has been developed as a short but informative overview of a multi-agency response for TSH. Further work is being completed to define a multi-agency Memorandum of Understanding that will help to further define roles and responsibilities of ourselves and partner agencies.

Level 3 plans are still fit for purpose and a multi-agency exercise is currently being planned for Quarter 3.

Level 2 Plans

TSH level 2 plans are primarily Loss of Service Plans and are led by internal operational structures.

Ordinarily, a return to normal operations is swift and is controlled within normal service functions and operations.

Research and Development

Within the NHS, it has been shown that research not only furthers knowledge but improves staff morale, recruitment and retention, and patient care. TSH has demonstrated considerable commitment to research and has a proven track record in published research and development of evidence based practice. In 2022/23 TSH staff were involved in the production of 11 peer reviewed publications. TSH Research Committee aims to support the use of data and research evidence as part of an evidence based culture aimed at improving both patient care and the patient experience of care, though a focus on continuously improving practice. The Research Committee approved six new studies in 2022/23 with 14 research studies continuing. Priority research themes are identified through engagement across the research community and inform the focus of future research supported by the committee.

In 2023/24 a new Research Strategy will be developed.

TSH hosts an annual Forensic Network Research conference, which disseminates current evidence.

Public Inquiries

With the commencement of the UK and Scottish Public Inquiries into the Covid-19 pandemic, there has been a requirement to review available resourcing within the workforce to ensure that The State Hospitals Board for Scotland is in a position to respond appropriately to each Inquiry. TSH has not previously had direct involvement or been requested to provide evidence to an ongoing Public Inquiry process. Given the size of the Board, there is a lack of opportunity to utilise redeployment of staff. Lack of available staffing was assessed as a potential risk given the

expected level of input expected from all NHS Boards through each Inquiry. Further, that preparatory work should not be delayed on assessment of information held and stored, as well as raising awareness of staff and providing supportive mechanisms to them should they be expected to be involved.

Therefore, the role of Board Lead has been aligned to the Head of Corporate Governance role, and a further temporary secondment role (Business Manager) has been funded and aligned to the Corporate Services Team. This is initially for 12 months for 2023/24; the post will be reviewed before the end of this period in terms of the real possibility that it will be required in the longer term to support this workstream.

APPENDIX A

	10 Recovery Drivers	TSH Specific
1	Improved access to primary and community care to enable earlier intervention and more care to be delivered in the community	Relevant to primary care access on site and the provision of physical health improvement
2	Urgent and Unscheduled Care – Provide Right Care in the Right Place at the right time through early consultation, advice and access to alternative pathways, protecting inpatient capacity for those in greatest need	Not applicable
3	Improve the delivery of mental health support and services	Applicable to overall ADP
4	Recovering and improving the delivery of planned care	Not applicable
5	Delivering the National Cancer Action Plan	Not applicable
6	Enhance planning and delivery of the approach to health inequalities	Applicable to overall ADP
7	Fast track the national adoption of proven innovations which could have a transformative impact on efficiency and patient outcomes	Where appropriate
8	Implementation of the Workforce Strategy	Applicable to overall ADP
9	Optimise the use of digital and data technologies in the design and delivery of health and care services for improved patient access	Applicable to overall ADP
10	Climate Emergency and Environment	Applicable to overall ADP

	Care & Wellbeing Portfolio	TSH Specific
1	Anchor Organisations (Place and Wellbeing)	Applicable to overall ADP
2	Getting it Right for Everyone	Applicable to overall ADP
3	Preventative and Proactive Care	Applicable to overall ADP
4	Waiting Well	Applicable to overall ADP

APPENDIX B

The State Hospital: 1991

The State Hosptial: 2022

Mental Health Directorate
Hugh McAloon, Director of Mental Health

T: 07904-330-057
E: DirectorofMentalHealth@gov.scot

Gary Jenkins
The State Hospital

By Email

30 August 2023

Dear Gary,

THE STATE HOSPITAL: ANNUAL DELIVERY PLAN 2023/24

Thank you for sharing your Annual Delivery Plan (ADP), setting out your operational priorities and key actions for 2023/24. May I take this opportunity to thank you and your team for all the hard work that has gone into the preparation, and subsequent review, of the ADP over the last few months.

As set out in the Delivery Plan Guidance issued earlier in the year, the 2023-24 ADP process is intended to move us forward from the volatility of the last three years and make further progress along the path towards recovery and renewal as set out in *Re-mobilise, Recover, Re-design: the framework for NHS Scotland*.

In support of this, the guidance was framed around 10 'drivers of recovery', which were then modified for each of the National Boards, and we welcome the considered way in which you have responded to these when developing your 2023/24 Plan.

Following discussions between our teams, I am now satisfied that your 23/24 Annual Delivery Plan broadly meets our requirements and provides a clearly shared understanding between the Scottish Government and the State Hospital regarding what is to be delivered in 2023/24.

There were a small number of areas which required some more detail or additions and these were indicated to your team after the first pass of the annual delivery plan. These have also been discussed at length between your team and the sponsor team. Whilst these areas have been addressed in the final version of the annual delivery plan, they should also be discussed and given focus in your progress update for April to September 2023. The areas that required more details or additions can be seen set out below in **Annex A** alongside the general feedback originally provided to ensure an audit trail is maintained.

Moving to focus on delivery of the Plan, we will engage with you on progress against the Plan, and any issues and risks which are impacting, or could impact, on delivery through the normal cycle of sponsorship meetings, bringing in colleagues from SG Health Planning for quarterly ADP reviews.

I am aware that you met with Paula Speirs, NHS Deputy Chief Operating Officer to discuss medium term planning for the State Hospital. At this meeting, it was agreed that the State Hospital would not submit a medium-term plan (MTP) at this time. Medium term planning remains a key activity, and as such, a new commission for a State Hospital MTP will be issued in due course. This will be in line with the progress and outcome of Recommendation One of the Barron Review and can reflect agreed outcomes on the work you are leading on regarding high secure care for women.

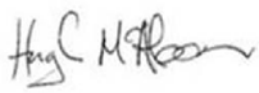
Looking ahead, we will continue to build on the foundations of the annual planning process and in doing so we will consider the very helpful feedback received from National Board Directors of Planning. In particular, we will work to ensure the ADP planning and reporting cycle is better integrated with financial and workforce planning, as well as enhanced regional and national planning. Our intention is also to bring forward the planning timetable for 2024/25, with the aim of finalising ADPs earlier in the year, and we look forward to working with your Planning team on this to ensure we can meet this aim without placing undue pressure on Boards during busy periods.

In particular, as a National Board, we are keen to work with you around how we improve the process of planning and commissioning and on how we can improve coherence and collaboration across the organisations that collectively make up NHS Scotland.

Once again, many thanks to you and all your colleagues, and we look forward to continuing to work with you as we plan and deliver the highest possible quality of care for patients, improve the experience of our staff and ensure the best possible value for citizens.

If you have any questions about this letter, please contact Alexander Malpass in the first instance (alexander.malpass@gov.scot).

Yours Sincerely,



Hugh McAloon

Annex 1: The State Hospital 2023/24 ADP Areas for Further Engagement

Feedback outlined in the Annex is aligned with the NHS Scotland Recovery & Renewal Drivers of Recovery and deliverables which are specific to The State Hospital. These can be seen outlined below.

NHS Scotland Recovery & Renewal Drivers of Recovery:

1	Improved access to primary and community care to enable earlier intervention and more care to be delivered in the community
2	Urgent & Unscheduled Care - Provide the Right Care, in the Right Place, at the right time through early consultation, advice and access to alternative pathways, protecting inpatient capacity for those in greatest need
3	Improve the delivery of mental health support and services
4	Recovering and improving the delivery of planned care
5	Delivering the National Cancer Action Plan (Spring 2023-2026)
6	Enhance planning and delivery of the approach to health inequalities
7	Fast track the national adoption of proven innovations which could have a transformative impact on efficiency and patient outcomes
8	Implementation of the Workforce Strategy
9	Optimise use of digital & data technologies in the design and delivery of health and care services for improved patient access
10	Climate Emergency and Environment

Specific deliverables for The State Hospital:

1. **MENTAL HEALTH**
2. **HEALTH INEQUALITIES**
3. **WORKFORCE**
4. **DIGITAL SERVICES AND TECHNOLOGY**
5. **CLIMATE EMERGENCY AND ENVIRONMENT**
6. **SECURITY**
7. **PATIENT PHYSICAL HEALTH**
8. **PATIENT PATHWAYS**

Recovery Driver	TSH Deliverable Reference	General Feedback and for Further Discussion
1	**N/A**	N/A
2	**N/A**	N/A
3	**1. MENTAL HEALTH**	Rewording suggested to the 'Forensic Collective', this has now changed to 'the new strategic planning and governance structure'. Realistic Medicine approach has now been spelt out in the final draft after discussion was had regarding expectations around sponsorship arrangements, overall approach to the action plan and governance arrangements.
4	**N/A**	N/A
5	**N/A**	N/A

6	**2. HEALTH INEQUALITIES**	Timeline to agree Anchors Strategic Plan to be communicated and reference made to establishing governance arrangements. From this, a line was added in the final version of ADP to show where governance will sit. Anchors Strategic Plan to be discussed going forward, including the timeline.
7	**N/A**	N/A
8	**3. WORKFORCE**	There was an expectation to see reference to engagement with workforce regarding interim retire and return arrangements to improve retention. This has now been added to the final draft regarding supplementary staffing. Ongoing discussions will be had regarding staffing and retention schemes.
9	**4. DIGITAL SERVICES AND TECHNOLOGY**	The ADP references national programmes, however, is top line and does not contain specific detail. This is due to the consultation phase in which TSH is currently standing at. Timescales and specific references cannot be made until this step completed. Sponsor teams will ensure that this is discussed in the quarterly updates and meetings.
10	**5. CLIMATE EMERGENCY AND ENVIRONMENT**	Specific discussion around objectives for DL (2021)38 to meet targets, as well as reference to supporting circular economy. These have already been achieved and do not feature in the final draft. Climate and environment will continue to be discussed in quarterly updates.

THE STATE HOSPITALS BOARD FOR SCOTLAND

BOARD MEETING

Date of Meeting:	26 October 2023
Agenda Reference:	Item No: 19
Sponsoring Director:	Finance and eHealth Director
Author(s):	Deputy Director of Finance
Title of Report:	Financial Position as at 30 September 2023
Purpose of Report:	For noting - update on current financial position

1 SITUATION

This report provides information on the financial performance, which is also issued monthly to Scottish Government (SG) along with the statutory financial reporting template.

The Board is asked to note the Revenue and Capital Resource outturn and spending plans.

2 BACKGROUND

The approved annual operating plan for 2023/24 has been submitted to SG, approved and signed off.

Any remaining residual Covid-related costs are now recognised through specific directorates under "business as usual" and will continue in this manner with due recognition of the resultant pressures from any additional posts therefrom.

Any delay costs from the Perimeter Project, which are being monitored by the Project Board and are reported directly to the Board, are reviewed, quantified for consideration, and reported appropriately.

3 ASSESSMENT

3.1 Revenue Resource Limit Outturn

The annual budget of £43.86m is primarily the forecast Scottish Government Revenue Resource Limit core and non-core allocations, together with any additional allocations as anticipated on a recurring basis.

A letter was issued on 1st August from the SG Director of Health Finance and Governance notifying National Boards that there would be a potential 5% or 10% reduction and clawback regarding additional in-year allocations, in order to reduce overall national sexpenditure and increase savings. While the notification specifically excludes TSH's allocations at this stage, we need to

remain aware of such pressures and highlight the fact that such options are under consideration across NHSScotland.

In addition, through the regular liaison meetings held with SG, we have been asked to confirm at regular intervals between now and 31st March our anticipated outturn for the year – with the implication that, if at any time a forecast underspend is noted, then some return of allocation to SG will be required to help address national pressures.

The September accounts show an underspend to date of £0.317m, which is marginally more favourable than the forecast trajectory at this stage of the year. This is in part due to vacancies and backdated Medical recharges.

PAIAW ("Payment as if at work") funding continues to be held as a reserve for the current year, and released monthly to match actual cost. This continues to be a significant element for the Board regarding our high levels of overtime and high nursing vacancies.

Some pressure also potentially remains re prior years' PAIAW still outstanding – with claimants now being in the hand of CLO (and some of whom have now recently been paid). This was accrued in 2022 and again at March 2023.

In the previous year, some costs of the project works started in 2021/22 re the eRostering project *(see para 3.2)*, M365 licences, and related pressures were accrued to fund an element of anticipated costs in 2022/23 – from this any unutilised elements have been carried forward to 2023/24.

3.2 Key financial pressures / potential benefits.

Revenue (RRL): -
Covid-19
Some posts have been reviewed for permanency, and a schedule of such posts is collated for review and consideration and is being addressed.

eRostering Project
While provision was noted for the contractual implementation costs of the eRostering project in 2022/23, this project is now rescheduled nationally by NSS to implement across 2023/24 and 2024/25. Additionally, currently unfunded are the additional posts potentially required in order to manage this implementation – being two posts requiring an annual funding of approx. £83k. This pressure has been highlighted and is being addressed.

Clinical Model review update
Current indications are that the budget for overtime should remain in place, while savings targets have been set at 2% - anticipated from leavers at higher points in the bands' scales being replaced with starters at lower points of the scales.

Energy and inflation increases
The rising costs of energy supplies and the knock-on effect on other supply chain deliverables will continue to be closely monitored as it is expected that there could be significant pressure in 2023/24 – which remain uncertain and will be dependant on winter conditions.
Previously estimated at an increase of £300k (accrued March '23), this has now been revised to £550k.

Extra PH for Coronation holiday
It is noted that there is the cost of one day's additional holiday in 2023/24, recurring from 2022/23 (Platinum Jubilee) for the Coronation holiday.

Benefits
Travel underspend has resulted in relevant budgets being reduced in 2023/24, to reflect changed ways of working.

3.3 2023/24 Budget

The 2023/24 final budget template required by SG has been submitted, including revised savings requirements of £0.8m, with forecast breakeven.

As noted above, energy cost increases are anticipated in the coming year due to market price increases, and pressures are noted for taking forward of new posts and structures established through Covid.

While the capital budget for 2023/24 remains at a recurring level of £269k, capital priorities are monitored and agreed through the Capital Group, and requirements for spend in the coming year have been notified to CMT – also noting that additional project funding will be considered when appropriate for any priority projects not affordable through the recurring funding.

3.4 Year-to-date position 2023/24 – allocated by Board Function / Directorate

Directorates (Utilities extracted from Security)	Annual Budget £'k	Year to Date Budget £'k	Year to date Actuals £'k	Variance (budget less actuals) for period	Budget WTE	Actual WTE
Nursing And Ahp's	22,884	11,733	12,162	(429)	403.08	399.63
Security And Facilities	6,573	3,325	3,433	(108)	123.82	118.73
Utilities	732	366	363	2	0	0
Medical	3,307	1,655	1,509	146	22.75	17.40
Chief Exec	2,340	1,174	1,117	58	26.07	22.11
Human Resources Directorate	1,090	549	532	18	16.30	16.80
Finance	3,037	1,542	1,597	(56)	29.18	30.07
Cap Charges	2,868	1,434	1,437	(3)	0.00	
Misc Income	(200)	(100)	(196)	96	0.00	0.00
Central Reserves	1,230	648	56	592	0.00	0.00
	43,860	**22,326**	**22,009**	**317**	**621.20**	**604.74**

Nursing

- Spend continues to be assessed in detail against budgets to confirm accuracy of forecasting (to assist future budgeting). Unutilised central reserves have been phased Apr – Aug to offset the Nursing overspend.
  Further RRL will be required from Sept – Mar (to ba addressed through pay award funding adjustment). Currently a large number of vacancies affect the directorate outturn.
- Psychology vacancies have offset some ward nursing overspend.
- PAIAW and Overtime reserves are now being released monthly to match costs.

Security & Facilities

- Utilities costs have been extracted from Security to be shown separately in order not to distract the directorate budget from core activity. Funds accrued at March 23 are funding the pressure to date.
- There are remaining covid pressures for disposable items being used for patient food delivery, also food price increases are causing pressure in the kitchen and staff restaurant.
- Current overtime pressures are noted and are being monitored.

Medical

- Base budgets were based on March salaries and inflated by 2.5% for expected pay uplift in 23/24; these will be reviewed once the final pay circular is received.
- More Consultants' time is being recharged for work done at other Boards; this too will be reflected in budgets once pay circular is received (September increase noted with arrears due in October).

CE

- Current benefit is noted from vacancies.

HR

- Corporate training, with little spend to date, is contributing to the underspent, but forecast is for this to be utilised by year-end.

Finance

- eHealth strategic funds have been released to support fixed-term staffing pressures, with further contract costs also to be funded, and under review.

Capital Charges

- The budget has been adjusted in June 2023 to reflect the increase in 2023/24; which has been met from reserves.

Miscellaneous Income

- The budget recognises income billed for exceptional circumstance patients, with appropriate risk provision for older balances with boards with whom recoverable balances are being discussed.

Central reserves

- These were initially phased to Month 12 (March '24) – much of which has been released to offset the ward nursing overspend as noted above in 3.4, hence the currently large balance will reduce proportionately as year progresses.

4 ASSESSMENT – SAVINGS

Savings are phased evenly over the year (twelfths), and equate to approx. £0.8m (2%).

Cumulative Savings	Savings - Annual Target	Achieved to date	(under)/over achieved
Directorate	**£'k**	**£'k**	**£'k**
Chief Executive	(39)		(39)
Finance	(57)		(57)
Nursing & AHP's	(440)	276	(164)
Human Resources	(25)		(25)
Medical	(65)		(65)
Security & Facilities	(140)	35	(105)
Total	**(766)**	**311**	**(455)**
1/12ths of target	(383)	311	(72)

It should be noted that of the Hospital's budget only 15% of costs are non-pay related, certain boards also treat vacancy savings, or a proportion thereof, as recurring savings, we still class as non-recurring.

National Boards Contribution

The eight National Boards (formerly Special Boards) continue to work towards joint efficiencies and collaborative working. The recurring level of contribution to the collective £15m savings challenge which the Board agreed and approved for 2022/23 remained at £0.220m, with 2023/24 yet to be confirmed.

This has now been reflected in the base allocation so removed from anticipated RRL.

5 CAPITAL RESOURCE LIMIT

The recurring capital allocation anticipated from Scottish Government for 2022/23 is £0.269m, which is anticipated to be fully utilised with capital projects planned and agreed through the Capital Group. Certain projects are likely to require requests on a project-by-project basis to SG for additional funding, including anticipated backlog maintenance work required on the Hospital.

With regard to the Perimeter Security Project allocation, there are elements of delays in the project – now likely to be completing in 2023/24 Q4 – requiring carry forward of unspent monies. SG are fully up-to-date with the anticipated project outturn and conclusion.

CAPITAL CRL 2023/2024 AS AT SEPTEMBER 2023	ANNUAL PLAN £'k	YTD SPEND £'k
SECURITAS TECHNOLOGY LTD (previously Stanley)		74
THOMSON GRAY LTD		119
TSH STAFFING		102
BRICK & STEEL		43
PERIMETER SECURITY TOTAL	**555**	**337**
IM&T		17
CAPITAL CRL	**269**	**17**
Backlog Maintenance (awaiting funding)	**405**	**6**
Total CRL	**1,229**	**361**

6 RECOMMENDATION

The Board is asked to note the following position and forecast –

Revenue
The year to date position is an underspend of £0.317m. Forecast for the year remains for a breakeven position to be achieved (with the adjustment pending for final AFC funding from SG as pay increases are finalised).

Capital
Some projects are at the evaluation and quotation stage, with the forecast for the year for full utilisation of the annual allocation.

MONITORING FORM

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

THE STATE HOSPITALS BOARD FOR SCOTLAND

BOARD MEETING

Date of Meeting:	26 October 2023
Agenda Reference:	Item No: 20
Sponsoring Director:	Director of Finance and eHealth
Author(s):	Director of Finance and eHealth
Title of Report:	NIS Review Summary
Purpose of Report:	For Noting

1 SITUATION

The State Hospital (TSH) was subject to a compliance progress review by Cyber Security Scotland during October 2022, with the next stage review due in October 2023.

2 BACKGROUND

In 2020 the Scottish Health Competent Authority commissioned a three-year programme of audits and reviews of health boards to evaluate compliance with the Network & Information Systems (NIS) regulations. The initial audit programme has been completed and unless incident reports or significant system changes in a health board merit a more frequent audit exercise, audits are conducted every third year. In intervening years, Compliance Reviews are being undertaken – to which this report relates - the primary objective of the review being to review progress on implementing the recommendations from the initial audit and progress on the control requirements.

3 ASSESSMENT AND OUTCOMES

A considerable amount of evidence is submitted up front to the reviewers – each piece of evidence requested for the review being "mapped" to one or more controls set out. The documentary evidence is then reviewed and assessed for compliance.

3.1 REVIEW

The 17 categories of the review are as follows –

- Organisational Governance
- Risk Management
- Supplier Management
- Asset Management

- Information Security Management
- People
- Services Resilience
- Access Control
- Media Management
- Environmental Security
- Physical / Building Security
- System Management
- Operational Security
- Network Security
- Incident Detection
- Incident Management
- Business Continuity

3.2 OUTCOMES AND NEXT STEPS

While the compliance status outcome from the 2022 review was raised from previous reviews, this was only from 28% to 36%. Although TSH has a strong approach to Information Security, the review highlighted the lack of one individual being in the dedicated post of IT Security Officer, which is seen as a key aspect. However, due to the size of our Board and eHealth team, this post is combined with other duties in the role of IM&T Senior Infrastructure Analyst & IT Security Officer – consideration of this aspect is now in progress through HR and is being addressed as part of this review's return.

A significant programme of work began in early 2023 to reduce this level of risk exposure, and this was progressed as a priority. The individual assessment points in the review were all confirmed with allocated responsibilities across directorates for provision of documented processes in support of compliance.

These actions were tracked fortnightly by the monitoring group (Director of Finance & eHealth, Head of eHealth and IT Security Officer – reporting to Chief Exec). There was full engagement with the departments from whom contributions and evidence are deemed essential – principally eHealth, Estates, Health Records, HR, Information Governance, Risk and Security – and a considerable effort by all of those involved in prioritising this has provided a strong contribution.

This process provided initial submission of supporting evidence to each category point by our first internal review deadline of 30 June to allow full collation and assessment, with a structured template provided for each action to be addressed, documented and then submitted for collation.

Rolling reviews then continued to confirm the documentation provided and to assess what remained to be completed by the final submission deadline – with direct feedback and engagement between eHealth and each department. Any remaining outstanding evidence was then addressed before the final submission.

While the previous review was conducted wholly remotely, on 5 June 2023 the independent reviewed undertook a site visit at TSH which, with support predominantly from eHealth, Security and Estates, enable a fuller appraisal of the physical aspects of our site and systems. (It had been felt previously that it is essential given the nature of TSH to be able to demonstrate physically a number of areas of compliance which have not been fully understood by the reviewer being limited by documentation only.)

The outcome from this on-site review will not be issued until post-October as it is not stand-alone and is considered alongside the main body of evidence to be submitted electronically.

Submission of TSH's documentation was on time on 16 October, and we now await the outcome of the independent review.

3.3 POST REVIEW

As indicated in August, it should be noted that after the 2023 review and issue of the results therefrom, the Competent Authority who undertake the review will be arranging a meeting on site with the Non-Executive Directors to discuss the outcome. This is now confirmed for Wednesday 6 December.

4 RECOMMENDATION

The Board is to note the report, and the date of the outcomes discussion in December.

MONITORING FORM

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

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	26 October 2023
Agenda Reference:	Item No: 21
Sponsoring Director:	Finance and eHealth Director
Author(s):	Head of eHealth
Title of Report:	eHealth Annual Report
Purpose of Report:	For noting

1 SITUATION

In order for the Board to have an overview of the work carried out by the eHealth Department, an annual report is provided for consideration.

The eHealth Annual Report highlights the activities of the department during 2022/23 while also detailing work required for 2023/24. This includes work streams emerging from –

- Information team
- Infrastructure team
- Information Governance
- Project Management

2 BACKGROUND

The State Hospital's eHealth department builds on the national commitment to provide a suitable digital infrastructure for NHS Scotland, with a strong focus on delivering national initiatives and programmes. In addition, there are significant Board-specific projects which require to be addressed in order to maintain the desired level of provision for both staff and patient needs.

This report relates to the period April 2022 to March 2023 and provides an update in respect of the above work streams, in relation to contributing to the delivery of high quality service and developments based on identified needs in the short, medium and longer-terms – plus a note of priorities through 2023-24.

3 ASSESSMENT

The report highlights the main areas of activity and issues from 2022-2023.

Key achievements include:

- Integration of HEPMA and Rio EPR
- Upgrade to virtual environment software
- Upgrade of storage software
- Replacement of mobile phone management system
- Replacement of key safe system
- Continuation of digital inclusion requirements
- Patient Learning Centre refresh
- Deployment of Windows Advance Threat Protection (ATP)
- TSH suite of Tableau dashboards
- New functionality in Rio EPR

Actions for the next twelve months include:

- Disaster Recovery Test Plans:
- Office 365 additional functionality
- Patient digital inclusion ongoing development;
- Wireless network replacement

4 RECOMMENDATION

The Board is asked to note the progress outlined in the attached report for the year 2022/23 and the key plans for the coming period.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives?	The Report follows good practice and also links in with the eHealth Strategy
Workforce Implications	Not applicable
Financial Implications	No financial implications if approved
Route to the Board (Committee) Which groups were involved in contributing to the paper and recommendations?	eHealth SubGroup
Risk Assessment (Outline any significant risks and associated mitigation)	No significant risks identified
Assessment of Impact on Stakeholder Experience	None
Equality Impact Assessment	No identified implications
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	None identified
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One √ There are no privacy implications. □ There are privacy implications, but full DPIA not needed. □ There are privacy implications, full DPIA included.

THE STATE HOSPITALS BOARD FOR SCOTLAND

eHEALTH ANNUAL REPORT

2022-2023

Responsible Director	Finance and eHealth Director
Lead Author	Head of eHealth
Contributing Authors	IM&T Senior Infrastructure Analyst & IT Security Officer
Approval Group	The State Hospitals Board for Scotland
Effective Date	April 2023
Review Date	April 2024
Responsible Officer	Finance and eHealth Director

Contents

1 Overview

The reliance on the services provided by the eHealth Department continues to grow. All departments within eHealth have seen an increase in request for assistance, with both the Information and Project Teams still managing a blended approach function effectively through combining working from home with on-site working.

They has been a strong focus on the delivery of HEPMA integration with our EPR Rio and Patient Digital Inclusion. The Infrastructure Team continue to support this work while maintaining the digital systems we all use daily. The integration between our EPR Rio and pharmacy's HEPMA system was successfully implemented and is operating well. The information fed from HEPMA to Rio provides real time information on the medication status of our patients. It removes the reliance on paper systems and is updated daily to ensure accuracy of the record.

Infrastructure support was also supplied as an essential contribution to support the installation and deployment of the new Key system.

The shifting of priorities for the Infrastructure Team continues to be a regular occurrence. This is in part due to the difficulties in retaining and attracting infrastructure staff to the team. Assistance to resolve this situation has been provided by the HR and Communication teams. Vacant posts are now advertised on social media as well as traditional methods of advertising. It is hoped this new approach will be successful in attracting new staff to the team.

The rollout of Microsoft 365 continues to be a challenge. While still benefiting from email and Teams the additional benefits expected from M365 are still on hold due to national issues – in the main under the control of NSS. We expect, however, to start work on our new SharePoint site in the next year. This has been on hold due to restraints requested by the national Organisation Development Group for M365. This group will advise when M365 capabilities are available with SharePoint being their focus at present. We have implemented M365's Advance Threat Protection (ATP) on our computer estate, but have yet to gain benefits from the use of Advanced Data Loss Prevention (ADLP), and Microsoft Information Protection Sensitivity Labelling and Retention capabilities but it is hoped the ODG will deliver guidance soon.

Work is ongoing to replace our fleet of printing devices. The replacement was put on hold during the pandemic and the current products are now approaching "end of life". Printing is still needed by staff, but the number of prints has reduced as staff turn to digital solutions. This is also due to the wider use of laptops by staff. The replacement printers are being downsized to reflect this change in practice, and smaller devices will have lower rental costs and will provide additional welcome savings to the budget.

There has been significant investment and time in meeting the requirements of the Network Information & Security Directive (NIS). The directive is in its second implementation and is a requirement of all critical service providers in the Scottish Public Sector. It is not solely focused on digital system but on the resilience and delivery of service across the Board but digital is its focus. Our submission will be uploaded in October with the Interim Report to be released the week commencing 27th of November. A management meeting to review the report is scheduled for the 6th of December, with the final report released the following week. This process will be repeated yearly until 2025. This process is reported separately to the Board.

With the support of the Procurement Team, we also successfully tendered for a replacement for our existing wireless network. The present wireless network is end of life and is no longer supported by the manufacturer. The wireless network replacement came in under the expected budget and we expect the new wireless network to be in place by February 2024. This replacement will deliver enhanced security controls provided by the network control software and will also importantly allow the expansion of our wireless network to accommodate any future requirements of the Digital Inclusion programme.

Our present video visiting system will be discontinued in December this year. This is also due to the end of life of the national video conferencing system and the move to Microsoft Teams. A replacement system has been identified and is subject to testing, and Near Me will take over as our video visiting system. This change is also supported by the national video conferencing team. They provide the access, configuration, and support for the NearMe system and this change, once implemented, will ensure we have continued access to video system that can deliver our video visiting requirements.

2 Information and Business Intelligence Team

The Information and Business Intelligence team continues to improve how TSH data is recorded and analysed, working with a wide range of stakeholders including medics and managers to help embed data in everyday practice.

The TSH suite of Tableau dashboards has continued to grow – recent dashboards including the new HR Dashboard, Modified Working, Incidents, and the HLT Dashboard. Charts include aggregated figures for PRN, Incidents, Seclusions, Observation Levels, Complaints, plus Physical Activity, Timetables data and more.

Following the upgrade to V23, a major focus of the last year has been looking at ways to use the new functionality in Rio. For example, dashboards have been developed in Rio which show as tabs on each patient's case record screen/clinical portal, including timetable data, BMI, Physical Activity, Daytime Confinement, PRN and DASA charts.

3 Infrastructure Team

The infrastructure team provide the support needed to several projects within the hospital. They continued to monitor, maintain, and update the digital infrastructure and equipment and the operating systems the rely on. This is a continual part of the work this team undertake this work while supporting the system used to assist deliver patient care. A new remote access solution has been in development and subject to testing should go live in the new year. Management of our M365 accounts has provided the volume of calls for the IT Helpdesk. As staff numbers have increased, the affective management of our M365 licences is crucial to mitigate additional licence costs.

Significant projects delivered by this team included –

- Windows Advanced Threat Protection (ATP)
- Replacement of patient movement and tracking system devices.
- Upgrade to virtual environment software
- Upgrade of storage software
- Replacement of mobile phone management system
- Replacement of key safe system

The team continue to provide regular day to day support essential to the organisation both onsite and remotely.

4 Health Records Department

The department continues to provide significant support for the Information Governance team with Freedom of Information (FOI) and Subject Access Requests (SARS) now provided by the Heath Records Department. The need for this support has grown over the year due to the volume of request received under FOIs and SARs. Further detail re the records department is contained in the IG Annual Report.

5 Information Governance

The workload of the IG team has continued to grow over the last year. This has been supported by medical records staff to ensure timescales for FOIs and SARs are met. SARS have caused significant load on the team with time extensions requested due to the large scale of some requests. National commitments have also increased while inter health board cooperation still continues to be a challenge. As in prior years, a separate Annual Report is presented from the IG team.

6 Project Management

The focus of the project team this year has been on identifying the possible needs and solutions to support our patients' digital inclusion needs. This required an extensive range of activities including meetings with the digital inclusion group, key stakeholders, security and clinical departments. The project team have also consulted other high secure hospitals and other organisations within the four nations to ask what plans they have relating to Digital Inclusion.

The culmination of this work was presented to CMT this year with the final stage of the process being a digital inclusion workshop in October with attendance from all areas of the hospital. The output of this workshop will form the final specification output for the future programme of patient digital inclusion at TSH.

The project team are also still involved closely with the national groups for the Microsoft 365 programme. They are also waiting for guidance from the ODG on the next stages of the M365 program that will be delivered. This project has been challenging but this has been recognised and will be delivered in line with national guidance.

Other projects being managed by the project team are:

- NSI Finance Dashboards
- Microsoft 365
- National Catering Information System (NCIS)
- Patient Bank/Kiosk System
- Ricoh Printer Replacement
- Replacement of Video Visiting system

The Project Management Team still continue to support colleagues through the Project Approval Process – including developing the new approval flowchart and guidance – and maintaining the Project Register.

7 Future Priority eHealth Projects – 2023-2024

- Disaster Recovery Test Plans:
- Office 365 additional functionality.
- Patient Digital inclusion.
- Wireless Network expansion.
- CORE Network Switch replacement
- Internet Reporting system

8 Digital Inclusion

The key projects currently under development being focussed on are –

- Video Visiting – change to Near Me Platform
- Patient Interactive Education Resource

Consideration is now being given to future priorities –

- Replacement of OneLan Screens
- Used of Cloud based systems
- Use of Cloud Based Storage

This programme is also reported separately in full detail to the Board.

9 Cyber Security

The second incantation of the NIS audit process takes place in October 2023. Changes have been made to the criteria for this audit after a review of the previous audit. NIS evidence previously submitted is still valid although needs expanded. After significant focus on the NIS requirements, we expect to see an increase in our compliance position this year. Cyber security is a constant concern for the eHealth department but all staff have a responsibility to work safely in the digital world. Guidance and education is still provided to staff by the IT Security module on LearnPro and by the newsletters distributed throughout the year.

Our monitoring system has continued to be effective with several malicious files being quarantined and disabled before causing any harm. 24hr monitoring of our digital traffic is still provided by NHS National Services Cyber Security Operations Centre (CSOC) Team and the SWAN Team at Capita. We still receive security notifications regarding TSH staff and malicious emails. The alerts continue to be recorded and reported at the eHealth Sub Group. Any actions taken by the IT Infrastructure and IT Security Manager and the infrastructure team are recorded on the Datix system for further investigation by the Risk team. At present our systems have been fit for purpose but, as cyber-attack vectors change, vigilance and education is key to ensuring we continue to be virus free.

10 eHealth Collaborative Working

Collaborative working has continued to be prevalent, and has developed further over the last year. This has grown particularly with the use of Teams, with the eHealth department continuing to represent the hospital at several national eHealth groups, and work where possible with other National or Territorial Boards. We continue to have sight of national programs and projects within NHS Scotland, and benefit from national solutions wherever practical and applicable.

The groups on which State Hospital eHealth staff are represented include –

eHealth Leads Group,
National Infrastructure Group,
National IT Security Group,
National Board Digital Group,
West of Scotland Infrastructure Group,
West of Scotland IT Security Group,
Office 365 Project Group.
M365 Renegotiation Team

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	26 October 2023
Agenda Reference:	Item No: 22
Sponsoring Director:	Finance and eHealth Director
Author(s):	Information Governance and Data Security Officer
Title of Report:	Information Governance Annual Report
Purpose of Report:	For noting

1 SITUATION

In order for the Board to have an overview of the work carried out by Information Governance, an annual report is provided for consideration. The Annual Report highlights the activities during 2022/23.

2 BACKGROUND

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 – reporting to the Finance, eHealth and Audit Group.

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.

The Committee has, over the course of the year continued to work to improve Information Governance standards and practices across the Hospital.

3 ASSESSMENT

The report highlights the main areas of activity and issues from 2022/23.

Key areas of work addressed include:

- Information Governance Standards (DPCT);
- Information Governance.Risk Assessments;
- Information Governance Training, including national events;
- Personal Data Breaches;
- Electronic Patient Records;
- Information Governance Walkrounds;
- FairWarning;
- Records Management;
- Freedom of Information;
- Subject Access Requests;
- MetaCompliance;
- ICO Audit.

Actions for the next twelve months include the on-going implementation of the ICO audit action plan, the continuance of all of the above aspects under an increasing national scrutiny and focus, plus addition work in the following areas:

- Records Management plan resubmission;
- Support for the NIS Audit;
- Introduction of a Subject Access training course.
- Replacement / Upgrade of MetaCompliance

4 RECOMMENDATION

The Board is asked to **note** the progress outlined in the attached report for the year 2022/23 and the key plans for the coming period.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives?	The Report follows good practice and also links in with national Information Governance developments and requirements
Workforce Implications	Not applicable
Financial Implications	No financial implications
Route to the Board (Committee) Which groups were involved in contributing to the paper and recommendations?	Information Governance Group
Risk Assessment (Outline any significant risks and associated mitigation)	No significant risks identified
Assessment of Impact on Stakeholder Experience	None
Equality Impact Assessment	No identified implications
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	No identified implications
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One √ There are no privacy implications. □ There are privacy implications, but full DPIA not needed. □ There are privacy implications, full DPIA included.

THE STATE HOSPITALS BOARD FOR SCOTLAND

INFORMATION GOVERNANCE ANNUAL REPORT

APRIL 2022 – MARCH 2023

(Including Health Records)

Lead Author	Director of Finance and eHealth / Senior Information Risk Owner
Contributing Authors	Records Services Manager
	Information Governance and Data Security Officer
Approval Group	The State Hospitals Board for Scotland
Effective Date	April 2023
Review Date	April 2024
Responsible Officer	Director of Finance and eHealth / Senior Information Risk Owner

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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.

These are recorded and monitored through the Information Governance Toolkit and Data Protection Compliance Toolkit (DPCT), and the Caldicott Guardian principles are fully integrated within the initiatives and standards required by NHS QIS for Information Governance. Although there is no longer a requirement to send the attainment levels to QIS or ISD, we continue to internally monitor our attainment levels biannually on this basis to ensure maintenance of the required standards.

This report is submitted on an annual basis to the Board, through the State Hospital's internal governance and approval structure.

The Committee has, over the course of the year continued to work to improve Information Governance standards and practices across the Hospital. We encourage 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.

In November 2022, the State Hospital (TSH) agreed to a consensual audit by The Information Commissioner's Office (ICO), who is responsible for enforcing and promoting compliance with data protection legislation and undertakes such reviews through article 58(1) of the UK General Data Protection Regulation (UK GDPR). ICO used their Accountability Framework as the basis for the audit, and its themes were organisational structure; policies and procedures; training for specialist IG roles; transparency; contracts with contractors; and data breaches.

The outcome of the review was an overall rating for The State Hospital of "High" ("a high level of assurance that processes and procedures are in place and are delivering data protection compliance"), and there were 12 recommended actions to be taken forward – all of which have been accepted. These are all now underway with specific agreed timeframes, to be monitored through regular quarterly reporting to the Information Governance Group.

This review was a major piece of work for the Hospital during 2022/23, and should be seen as a positive reinforcement of our IG Strategy.

We have also 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 walkrounds within the Hospital – while interrupted by the restrictions required as a result of the Covid crisis – have now resumed in the last year, including non-patient areas. In addition, the group has continued to focus on other key areas of priority such as the electronic patient record (EPR) system and the outcomes of the FairWarning system – together with ad hoc issues such as record retention and email scams.

2 INFORMATION GOVERNANCE GROUP

2.1 Information Governance Group membership

Director of Finance and eHealth (Chair)
Associate Medical Director/Caldicott Guardian
Head of e-Health
Clinical Secretary Co-ordinator
Information Governance and Data Security Officer & Data Protection Officer
Senior Infrastructure Analyst & Information Technology Security Officer
Lead Nurse
Health Records Manager
Psychology Representative
Security Information Analyst
Finance Representative
Social Work Representative
Human Resources Representative
Health Centre Representative
Lead Pharmacist
AHP Representative
Risk Management Representative
Dietetics Representative
Procurement Representative
Board Secretary
Skye Centre 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 DPCT.
- Address issues arising in the hospital in relation to Data Protection.
- Address issues arising in the hospital in relation to Records Management 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 Information Governance issues and to receive feedback from Information Governance on such matters.
- To monitor requests made in relation to Freedom of Information and Data Subject Rights Requests.

2.4 Meeting frequency

The group meets on a quarterly basis to discuss any issues as outlined above, however the terms of reference have been updated to add the option to hold ad-hoc meetings following a recommendation from the ICO audit. Following agreement from the wider group, a small subgroup – the Information Governance DPCT Group – meets 6 monthly in order to concentrate on the assessment of the current attainment levels and supporting evidence required for the DPCT. In addition, another small subgroup 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 and Data Protection Compliance Toolkit (DPCT) are completed twice yearly in order to monitor the performance of the hospital in relation to Information Governance.

The schedule of work for the subgroup is compiled in such a way as to allow the group to review progress with DPCT. 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..

2.6 Management arrangements

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

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

3.1 Information Governance Standards

The Information Governance standards was retired at the end of 2021 and was replaced with the Data Protection Compliance Toolkit (DPCT). It has been developed from ICO's accountability framework, which supports the foundations of an effective privacy management programme.

The toolkit is divided into 10 categories, within each category there are a set of statement and questions that are rated on a 1 – 4 scale

Level	DPCT Status
1	Expectations not met
2	Expectations partially met
3	Expectations met without review cycle
4	Expectations fully with review cycle

Category	Level 1	Level 2	Level 3	Level 4	Status
1. Leadership and Oversight	0%	52%	48%	0%	**Level 2**
2. Policies and Procedures	6%	47%	47%	0%	**Level 2**
3. Training and Awareness	19%	52%	29%	0%	**Level 2**
4. Individuals' Rights	20%	34%	46%	0%	**Level 2**
5. Transparency	31%	50%	19%	0%	**Level 2**
6. Records of Processing and Lawful Basis	25%	50%	39%	0%	**Level 2**
7. Contracts and Data Sharing	11%	39%	50%	0%	**Level 2**
8. Risks and DPIAs	10%	38%	52%	0%	**Level 3**
9. Records Management and Security	16%	51%	33%	0%	**Level 2**
10. Breach Response and Reporting	16%	76%	8%	0%	**Level 2**
Overall	**15%**	**49%**	**36%**	**0%**	**Level 2**

Whilst the DPCT shows a range of attainment, this year's position was expected due to the implementation of a new method of monitoring compliance.

It has not possible to reach any level 4 status this year, this is because to achieve a level 4 status the control point needs to have been recorded in the DPCT as "fully met" for over a year and as the DPCT has not been operating for a full year yet.

It is anticipated that the majority of the current level 3 attainments will become level 4 next year.

Work continues in conjunction with the recommendations from ICO's audit to improve the organisations compliance status.

3.2 Information Governance Risk Assessments

Information Governance risks assessments are undertaken by a subgroup of the IGG – the IG Risk Assessment Group – comprising the Caldicott Guardian, Record Services Manager and Information Governance and Data Security Officer. The group first met in November 2011 to update risk assessments following the move to the current hospital site. Following on from this the subgroup try to meet on a 6 monthly basis to review current Information Governance risk assessments and update accordingly. The Group last met in October 2022 and the next meeting is planned for 4 August 2023.

There are currently four open Information Governance risk assessments on the risk register covering a variety of risks (e.g. failure to communicate a change in access requests to eHealth in a timely manner). All four risks are currently at or below their target risk rating of medium.

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).

The Risk Assessment Group is currently working through registered risks to update them to reflect new technologies and working practices such as Teams and remote working. Reports are now provided to the group on all relevant incidents recorded through Datix and the DPO register of personal data breaches. The Group is changing its working methodology to be more proactive rather than reassessing out of date risks – this has had an impact on the efficiency of the Group however this is now being rectified and the upcoming meeting will ensure the Group is back on track.

3.3 Information Governance Training

The majority of Information Governance training for staff is delivered online via LearnPro. 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.

Information Governance module completion					
Module	**Mar 2019**	**Mar 2020**	**Mar 2021**	**Mar 2022**	**Mar 2023**
IG: Essentials	81%	70%	78%	76%	95%
Confidentiality	96%	98%	98%	98%	98%
Data Protection	96%	98%	98%	97%	98%
Records Management	95%	98%	98%	98%	98%

Following a few years where attainment dipped below 80%, 2022/23 saw a training return to expected levels.

The Confidentiality, Data Protection and Records Management modules were reviewed and updated in line with current legislation and were issued at the start of the financial year.

In addition to the online modules Information Governance offer on demand training that has delivered 19 Data Protection Impact Assessments training sessions and 5 Freedom of Information sessions.

3.3.1 National Training Events

In November 2022 The State Hospital hosted the second Data Protection Officers training day on behalf of NHS Scotland. The event was attended by almost all Scottish health boards and was well received by all the delegates.

Courses that cover the specific tasks and skills for DPOs are not common and as most organisations only have 2 to 3 individuals needing trained the costs of using publically available courses starts around £150 per person.

By partnering with other boards not only were we were able to reduce the cost of training DPOs across NHS Scotland substantially, but we were able to have the course tailored to NHS Scotland's specific needs.

No further national events are planned for next year, however discussions have taken place at a national level to see if an ongoing national training plan can be put in place.

3.4 Category 1 & 2 Investigations

There were no Category 1 or Category 2 investigations related to Information Governance during the year.

3.5 Personal Data Breaches

Under the UK GDPR there is a requirement to record personal data breaches. In cases where there is a high risk to the individuals involved, these breaches must be reported to the Information Commissioner's Office no later than 72 hours from discovery. The State Hospital uses Datix to record potential breaches of personal data.

Reported Personal Data Breaches				
	2019/20	2020/21	2021/22	2022/23
Reported Breaches	16	19	56	35
Required ICO Notification	0	0	0	0

There were 35 recorded personal data breaches in 2022/23 that were attributable to The State Hospital, which is a reduction over last year.

Area	Percentage
Leak to the Media	24%
Internal Email Disclosures	15%
Information Disclosed Externally	15%
Internal Mail System	15%
Others	10%
Information Unavailable When Needed	5%
Information Disclosed Internally (non-email)	5%
IT Account Settings	5%
Incorrect Information	5%

The majority of recorded breaches related to our communication platforms (email and physical post), however information passed to the media was the single largest category this year.

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

No breaches required notification to the Information Commissioner's Office (ICO).

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. RiO 22 went live on 08 March 2022 with a successful transition period. Following this we have moved quickly to introduce BAU process for ongoing development of RiO. A multidisciplinary project approval group (Rio Oversight and Development (ROAD) Group) has been established that reports to the eHealth Sub Group. Included within the approval process is appropriate information governance scrutiny.

Regular audits are carried out on various areas within Rio, with documentation and guidance updated as required. Issues are discussed at the Information Governance Group, or the ROAD Group.

A robust system is in place for Requests for Change to Rio – this may involve a quick assessment and authorisation by the system owner, or a more thorough review by members of the team including IG checks and workability.

Further work has been carried out to integrate links between Rio and the medication prescribing system (HEPMA) – a link for users from Rio to HEPMA is under development. The use of further modules to allow more flexible use of Rio (e.g. bedside) is also being explored. Grounds access processes are still under review however some advancement has been made and this is expected to go live in Autumn 2023.

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 walkrounds now occur a random throughout the year and encompass all areas of the organisation were personal information is used.

This year saw a return to Information Governance walkrounds, with the staff members involved in conducting these walkrounds noted the good standards of Information Governance that have been apparent in visited areas.

As with previous years 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.

The walkrounds compliment the Records Management plan and general information governance goals by providing an informal opportunity for staff to raise questions or seek guidance on specific aspects of their work as well as raising general awareness of information governance considerations.

3.8 FairWarning

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

FairWarning alerting rate remained consistent with last year and reflects changes in the patient population over the year. This is the seventh consecutive year in which no incidences of inappropriate access have been alerted via FairWarning.

The group continues to be satisfactory assured that there are no areas of concern regarding inappropriate access.

Whilst the focus of FairWarning is to detect potential inappropriate access to patient records, the sustained absence of such actions from any area of the organisation should be seen as a very positive statement about the professional conduct of staff.

The FairWarning platform was moved to NHS Scotland's cloud based FairWarning tenancy without incident.

3.9 Records Management

This year has been extremely busy but positive for the Health Records Department. The addition in staffing resources has meant that day-to-day workload is mostly manageable and there has been some movement in the wider Records Management workload.

The State Hospitals Board for Scotland submitted its Records Management Plan (RMP) to the Keeper of the Records in December 2016. The Plan was agreed and accepted by the Keeper with some elements graded as amber, and having work outstanding. A Plan Update Review (PUR) was carried out and submitted to National Records of Scotland (NRS) in October 2021. A positive response to this was received in December 2021, recognising the work that has now been carried out in areas such as the creation of a Corporate Records Policy and a formal Information Asset Register. As there have been noted improvements in Records Management within the organisation, a full RMP will be completed in late 2023 for submission to NRS for assessment and agreement. This was planned to take place earlier, however NRS are offering guidance surgeries on this later in the year so it seems sensible to attend these prior to resubmission.

One disappointing area during the year was the organisational change process and updated job descriptions being reviewed after a lengthy process, however not gaining the hoped for bandings. On a more positive note, the move to a separate service (Records Services Department) is well underway, with a split from eHealth taking place with some areas still to be ironed out. This is allowing the department to function independently and becoming involved in projects and work around the hospital, liaising with staff from various departments to promote RM in all areas.

Plans are in place to resurrect the Records Management Group with a meeting scheduled for June 2023, alongside updated Terms of Reference. A sub-group of the IGG is also being formed with responsibility for the oversight of clinical records – this is also set to meet for the first time in Summer 2023. A Quality Improvement project to reduce data held in shared drive space, and also to being using a Business Classification Scheme has begun although is at an early stage, and it is recognised that this work may take time.

Work on merging the current Health Records Policy Corporate Records Policy is planned to being in Autumn 2023. Work is also ongoing to create formal retention and destruction policies, as well as version control and naming convention guidance. It is hoped that this work will be completed by Autumn 2023.

Appraisal of patient records for permanent preservation or destruction has continued, with more records having been destroyed. Work is ongoing to gather metadata on items for permanent preservation with the National Records of Scotland. It has also been agreed that referral files for patients can now be appraised and destroyed if appropriate.

Work is being undertaken in relation the to the Hospital's Information Asset Register. This includes staff recording data as well as assisting staff to complete the process of registering systems and data held, whilst offering advice and encouragement to incorporate records management methodology.

Work relating to M365 is still ongoing with the Health Records/Records Service Manager being involved in national groups to ensure good RM is included in all areas. There is also national work to update the Records Management Code of Practice ongoing which the Health

Records/Records Services Manager is contributing to. Information and updates from this work is shared regularly with internal colleagues.

As 2023 celebrates the 75th birthday of the NHS, the department are looking to put on a display of historical artefacts and information relating to changes in how The State Hospital has developed throughout the years. This will focus on both clinical and non-clinical practices and it is hoped that this will engage a number of staff, and also some community liaison to provide a positive display of how far mental health treatment and support has come.

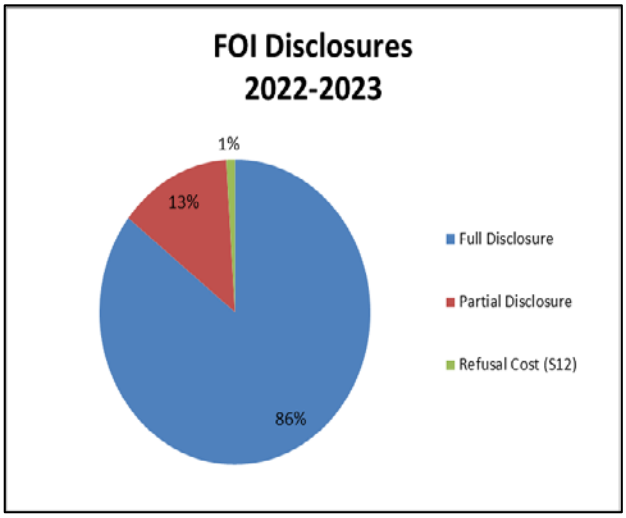
3.10 Freedom of Information

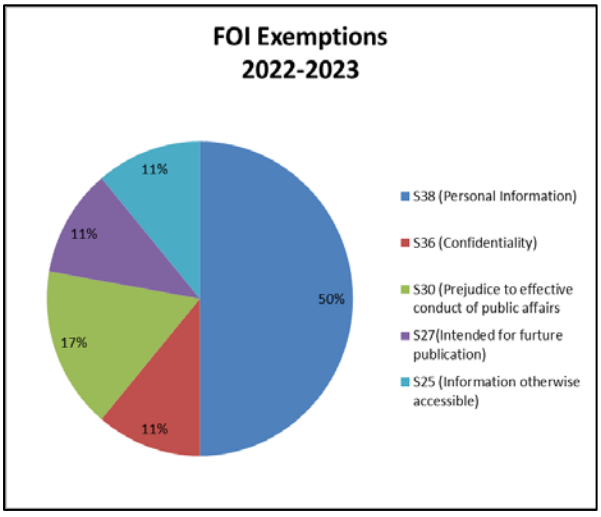
The group is kept informed of all Freedom of Information (FOI) requests and of the timescales achieved in responding to these. Requests have mainly come from the general public (62%), with the charities, lobby or campaigning group (11%) the second largest requestors. The recorded numbers of requests were down 17%.

Number of Freedom of Information Requests					
	2018/19	2019/20	2020/21	2021/22	2022/23
Requests made	33	224	262	172	145
Completion rate within timescales	94%	100%	89%	99%	91%

This year has seen a drop in requests for reviews, with all the reviews finding that The State Hospital's original response was an appropriate response, which required no modification.

Number of Freedom of Information Reviews					
	2018/19	2019/20	2020/21	2021/22	2022/23
Requests for review made	2	0	3	4	2
Upheld without modification	2	0	3	4	2
Upheld with modification	0	0	0	0	0
Substituted a different decision	0	0	0	0	0
Reached a decision where no decision had been reached	0	0	0	0	0





Where the organisation held information, it provided a full response to applicants for the majority of requests (86%).

Five exemptions were used to withhold or decline to publish information. In most cases (50%) this was because the answer to the request would identify an individual such as a patient or member of staff.

3.10.1 Freedom of Information Self-Assessment

The FOI Committee drive a continuing improvement cycle based on the Scottish Information Commissioner's self-assessment toolkit.

The toolkit comprises of six modules each reviewing a particular area of our FOI obligations providing a four-point scale of performance (Unsatisfactory, adequate, good and excellent) that reviews the year's performance. Modules 5 & 6 were introduced by the Commissioner in 2021/22.

Ratings	Meaning
Excellent	Greatly exceeds the requirements of FOI
Good	Exceeds the requirements of FOI
Adequate	Meets the requirements of FOI
Unsatisfactory	Below the requirements of FOI

Public authorities, such as The State Hospital, are expected to deliver an 'adequate' service, taking in to account their local setting.

Standards and Criteria	2018/19	2020/21	2021/22	2022/23
1. Responding on time	Good	Good	Good	Good
2. Searching for, locating and retrieving information	Adequate	Good	Good	Good
3. Advice and assistance	Adequate	Adequate	Adequate	Good
4. Publishing information	Adequate	Adequate	Adequate	Adequate
5. Conduct of Reviews	N/A	N/A	Good	Good
6. Monitoring and managing FOI performance Standards and Criteria	N/A	N/A	Good	Good
Overall	**Adequate**	**Adequate**	**Adequate**	**Adequate**

The assessment shows that the management of FOI requests continues to meet the requirements of the Freedom of Information (Scotland) Act. The overall rating is determined by the lowest score over the six sections and although the hospital's overall rating is "adequate", it is clear over the last 4 years that the organisation has made improvements to the FOI service and now exceeds the requirements in all but one section.

With the improvements to the hospital's Internet website and ensuring patients can access as much of the information about the organisation that the general public can, it is anticipated that the organisation will reach a "good" rating next year.

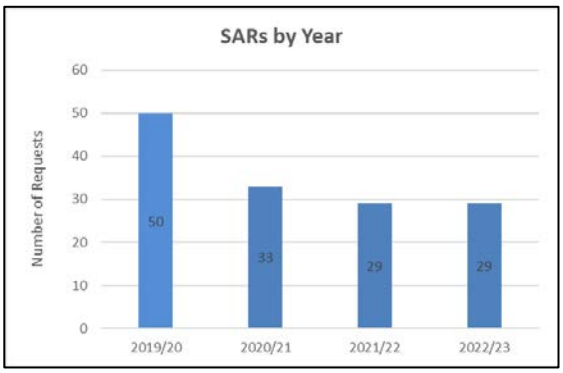
3.11 Subject Access Requests

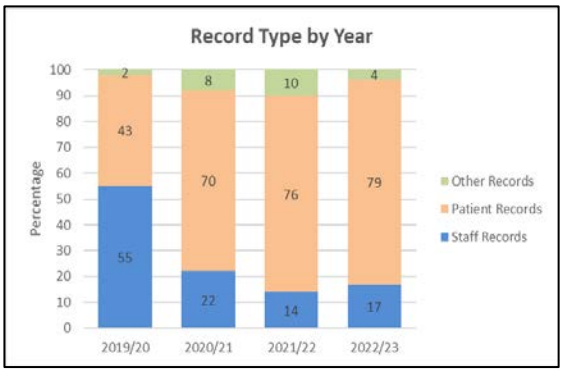
Subject access requests continue at expected numbers of requests with patient requests accounting for about 79% of all requests.

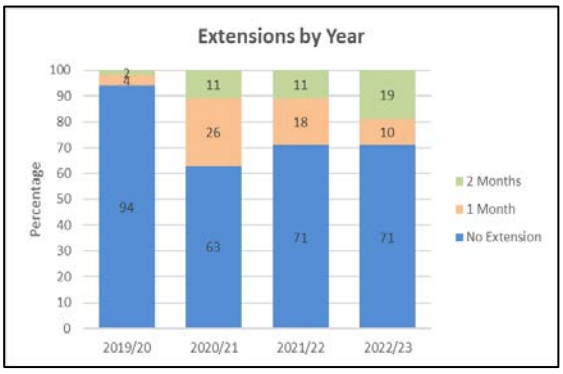
Whilst the number of requests has remained at the same level as last year, there were more requests this year for *all the information holds about a patient* than in previous years. These

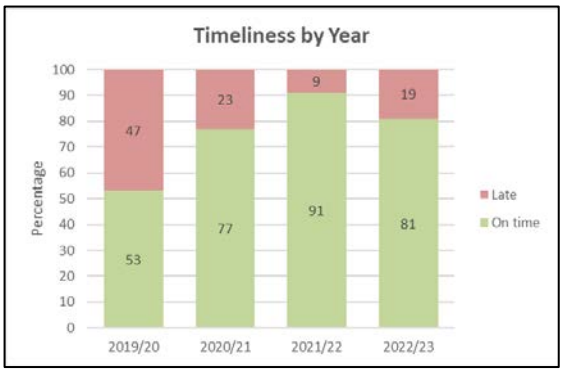
requests place a significant burden on the organisation as they can be in excess of 10,000 pages of information.

The added complexity of these requests is reflected in a higher number of 2 month extensions used than in previous years and they also account for most of the late responses this year.









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.

MetaCompliance is supported by the complimentary system MyCompliance which provides a way to acknowledge policies prior to MetaCompliance enforcing a response.

The current MetaCompliance service continues to provide assurance that policies are read and understood by members of staff, but following a review of the service's operation a project has started to replace the current version with a modern cloud based platform that would be allow more flexibility for staff and better reporting for the organisation.

Over the last year the number of policies delivered by MetaCompliance has dropped by 15% to 61. Most "All Staff" policies achieve around 88% awareness and agreement within three months of release. Whereas "Clinical" policies achieve around 84% awareness and agreement within the same timeframe.

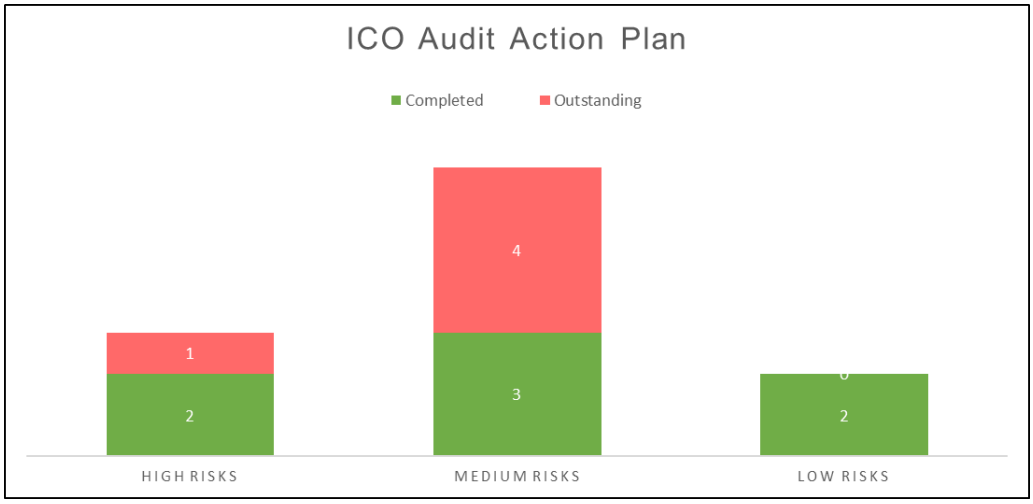
4 INFORMATION COMMISONER'S OFFICE AUDIT

The Information Commissioner's Office (ICO) audited the State Hospital to assess the risk of non-compliance with data protection legislation, the utilisation of ICO guidance and good practice notes and the effectiveness of data protection activities.

The audit was conducted in November 2022 with the organisation being awarded a high assurance rating.

Audit Scope area	Assurance Rating	Overall Opinion
Governance & Accountability/Data Sharing	High	There is a high level of assurance that processes and procedures are in place and are delivering data protection compliance. The audit has identified only limited scope for improvement in existing arrangements and as such it is not anticipated that significant further action is required to reduce the risk of non-compliance with data protection legislation.

The audit identified some areas were the state hospital could improve their compliance and following consultation with ICO a 12 point action plan was agreed to be completed over the next two years.



The organisation has already completed 58% of the action plan and work continues on the outstanding points.

5 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 – although continuing to have remote Teams meetings has encouraged a strong turnout. We encourage attendance by making the remit of the group relevant to staff members' roles, incorporating user feedback on eHealth matters into the agenda for the group. The attendance by deputies in the event of diary pressures is also now in place with a stronger emphasis for all members to encourage attendance.

The 2022 ICO review, as highlighted in section 1 - required significant time and resource to plan, manage and deliver, which served to highlight the resource pressures facing the IG function. These are being addressed in 2023/24 through collaboration with the Records team and will be monitored on an ongoing basis.

New technologies, such as increasing use of Teams (part of Microsoft Office 365), continued to support performance in 2022/23. However, while the timing remains unconfirmed and has been subject to a number of national delays, the anticipated introduction of Office 365 nationally will bring additional information governance challenges as NHS Scotland migrates to a cloud based hybrid working environment.

6 FUTURE AREAS OF WORK AND POTENTIAL SERVICE DEVELOPMENTS

Work/ Service Development	Timescale
Records Management Plan to be resubmitted	Late 2023/24
Historical display to celebrate NHS @ 75 to be held	July – September 2023
Provide support and input to the preparations for the NIS Audit (October 2023)	April – September 2023
Implement the action plan from ICO's audit	2023 - 2024
Reach 80% completion for the IG: Essentials learning module.	Ongoing
Maintain 85% completion for all other IG learning module.	Ongoing

7 NEXT REVIEW DATE

April 2024

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	26 October 2023
Agenda Reference:	Item No: 23a
Sponsoring Director:	Chief Executive Officer
Author(s):	Head of Communications
Title of Report:	State Hospital Annual Report 2022/23
Purpose of Report:	For Noting

1. SITUATION

The Head of Communications is required to produce a Communications Annual Report. This report covers performance from 1 April 2022 to 31 March 2023 in support of the Communications Strategy 2020/25. This update is provided as at 4 April 2023.

2. BACKGROUND

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

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

The two services predominately delivering internal and external communications are the Communications Service and the Person Centred Improvement Service (PCIS). This was another extremely busy year for both functions to keep effective and quality communication flowing.

3. ASSESSMENT

The Communications Service performed to a high standard, delivering a wide ranging and comprehensive communications service to stakeholders. Additionally, others responsible for delivering effective communications continued to achieve agreed objectives.

Overall, core Communications tasks including key performance indicators, quality assurance objectives and quality improvement objectives were delivered. All legislative requirements were met, and all financial targets / savings were achieved.

These achievements were made while adhering to the core values and ways of working that the Board sponsors and are promoted across NHS Scotland.

There is no doubt that the ongoing functioning and future proofing of the Communications Service will benefit from the investment in staffing in year (PR & Media Communications Officer was appointed in October 2022) to complement the previous single person resource. Service delivery will be further enhanced with the planned appointment of a PR & Digital Communications Officer in 2023/24. These posts will help address the growing backlog and enable the Service to explore more modern methods of communication to add variety and ensure existing methods do not become dated. More importantly, the challenges and risks associated with a sole post are now diminished. This much needed investment to sufficiently resource this important Service enables the best and most effective use of resources, and will build capacity for the future with an emphasis on appropriate resilience, succession planning, and growth.

The Memorandum of Understanding (MoU) with the NHS Golden Jubilee (established 2018) in respect of senior communications cover arrangements in the absence of the Head of Communications will remain in place until the new staff are more developed in their respective roles.

The Communications Risk Register (established around a decade ago) continues to outline local cover arrangements in the absence of the Head of Communications. The risk links to resilience in respect of a single person resource, and will be reviewed in 2023/24 when the two new appointments are in place.

4. RECOMMENDATION

The Board is asked to note the update.

MONITORING FORM

How does the proposal support current Policy / Strategy /ADP / Corporate Objectives	The Annual Report supports the State Hospital's Communications Strategy. The strategy supports legal obligations, local and national strategic objectives, quality assurance and quality improvement objectives, NHS values and behaviours, openness and transparency, professional standards, and best practice in PR and Communications.
Workforce Implications	The single service resource was enhanced with the appointment of a PR & Social Media Communications Officer in October 2022. A PR & Digital Communications Officer will be recruited in 2023/24.
Financial Implications	Cost associated with potential investment in staffing / resources during 2022/23 and 2023/24.
Route to Board Which groups were involved in contributing to the paper and recommendations.	Sponsorship and governance route: Head of Communications, Person Centred Improvement Lead (PCIL), and the Chief Executive.
Risk Assessment (Outline any significant risks and associated mitigation)	Investment in staffing will mitigate the significant risk associated with a single person resource.
Assessment of Impact on Stakeholder Experience	Promoting key messages and a positive image of the Hospital leads to improved public understanding of the State Hospital, mental illness, and helps to tackle associated stigma.
Equality Impact Assessment	Numerous EQIAs are in place to support the Communications Strategy and associated activity.
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	The Head of Communications works closely with the PCIL to support an inclusive approach to ensuring patients who experience significant barriers to communication are enabled to contribute meaningfully to all aspects of care and treatment.
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One □ There are no privacy implications. □ There are privacy implications, but full DPIA not needed ☑ There are privacy implications, full DPIA included. Numerous DPIAs are in place to support the Communications Strategy and associated activity.

COMMUNICATIONS SERVICE ANNUAL REPORT 2022/23

'ENABLING CHANGE'

1. CORE PURPOSE

Communication is at the heart of everything we do. Within the State Hospital, the core purpose relates to all aspects of communications both internally and externally - from consultancy / advice and guidance, to the provision of electronic communications, dealing with the media, social media, the production of corporate publications, and stakeholder engagement. Specifically, the Head of Communications acts as a communications link between the Hospital and stakeholders including staff, the local community, general public, professional bodies, and local and national government, and drives forward improvements in communication. This enables the influencing and shaping of communication planning and strategy at all levels, ensuring good communications practice is firmly embedded in everyday service development, delivery, and change.

Given the nature and organisational arrangements of the Board, patients are uniquely viewed as internal communication stakeholders in addition to Non-Executive Directors, Volunteers, the Chaplaincy Team, Patients' Advocacy Service, and staff. Carers, the public and the media are included within external communication arrangements, which differs from the Communications function of other Boards. The State Hospital's public (patients) are with us for an average of 6.5 years, and some very much longer, and therefore are classed as internal stakeholders. The public are potential patients of territorial Boards and are viewed by them as external stakeholders. These Boards will therefore undertake direct engagement with their public in relation to health, wellbeing and services provided.

The two services predominately delivering internal and external communications within the State Hospital are the Communications Service and the Person Centred Improvement Service (PCIS). These two services work very closely together with the PCIS having specific responsibility for patient, carer, and volunteer communication. Combined key results areas include Stakeholder Communications (Internal and External including staff, patients, carers, and volunteers), Public Relations (Relationship Management), Crisis Management, Public Affairs (Media and Political) and Marketing Communications.

This annual report covers the work of the Communications Service from 1 April 2022 to 31 March 2023. Communication activity with patients, carers, and volunteers during 2022/23 is captured in the PCIS 12-month update reports. Additionally, stakeholder stories presenting feedback from patients, carers, and volunteers directly to the Board continues bi-monthly.

Trust and confidence of our stakeholders can only be achieved through maintaining the highest levels of transparency. The work of the Communications Service and PCIS help drive our reputation locally, nationally, and globally through different channels by communicating with all stakeholders in a timely, accurate and consistent fashion. This in turn generates confidence, which ultimately supports the Board's Visions and Corporate Objectives.

The Communications Service firmly believes that our values are the bedrock of our culture, guiding how we work with one another and our stakeholders.

2. LOCAL AND NATIONAL DRIVERS

Communications is delivered in line with the State Hospital's Communications Strategy 2020/25, which meets the legal obligations contained within:

- State Hospital Annual Operating Plan (AOP) 2022/23.
- National Staff Governance Standard (4th edition), June 2012.
- NHS Scotland Healthcare Quality Strategy, May 2010.
- NHS Scotland 2020 Workforce Vision (*Everyone Matters*), June 2013.
- Healthcare Improvement Scotland (HIS) – 'What Matters To You?' August 2016.
- Human Rights Act 1998.
- Public Interest Disclosure Act 1999.
- Freedom of Information (Scotland) Act 2002.
- Equality Act 2010.
- Public Services Reform (Scotland) Act 2010.
- Patient Rights (Scotland) Act 2011.
- Mental Health (Care and Treatment) (Scotland) Act 2003 / 2015.
- Carers (Scotland) Act 2016.
- Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016.
- General Data Protection Regulations (GDPR) 2018.
- Duty of Candour Procedure (Scotland) Regulations 2018.
- Fairer Scotland Duty 2018.

3. COLLABORATIVE WORKING

A key aspect of the Communications Service is the requirement for effective and regular collaborative working across all directorate structures and teams. Being independent from other functions, services, or directorates, ensures effective broader organisational confidence, dialogue and connection is maintained. This is something that has been achieved over many years. Within the State Hospital environment, it is important for staff to be able to see a function that not only serves all staff and disciplines equally but is positioned correctly to do this through a joined up internal network of strong lines and links in all directions with communications at the centre.

Collaborative working with the Scottish Government Mental Health Team, Scottish Government Communications colleagues, Health Board Communications peers, the Mental Welfare Commission, and other partners is well established.

4. STAFFING / RESOURCES AND INVESTMENT FOR THE FUTURE

In 2021/22, the Board agreed to a resource review of the Communications Service in relation to its ability to meet the current and future aspirations of the Board, and the changing shape of communications. As a result, in March 2022, the Head of Communications was asked to produce an Options Appraisal for the April 2022 Board meeting that would ensure the most effective and efficient functioning and future proofing of the Communications Service. This led to two appointments: PR & Media Communications Officer in October 2022 (special focus on social media and video production) and a PR & Digital Communications Officer in May 2023 (with a specific focus on the website and intranet). Both posts will complement the existing single person resource being the Head of Communications.

5. KEY PERFORMANCE INDICATORS (KPIs)

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

No	KPI	Source	Timescale	Status / Outcome
01	To produce a Communications Annual Report for presenting to the Board.	Board	Annually	**Continues to be met**
02	To produce the Board's Annual Report.	Board	By 31 October each year	**Continues to be met**
03	To produce at least 44 weekly bulletins for staff.	CEO	Annually	**Complete** A total of 48 were produced.
04	To produce at least 40 special bulletins as a support to staff.	CEO	Annually	**Complete** A total of 45 were produced.
05	To produce Staff Newsletter 'Vision' twice a year as a minimum.	CEO	Annually	**Complete** Eight editions were produced: four regular editions, three Wellbeing special editions and one Excellence Awards special edition.
06	To deliver on 100% of all appropriate requests for Talks to the Community.	General Public	Annually	**Complete** One talk was delivered in April 2022.
07	To respond to 100% of urgent Media Enquiries within the timescale requested and within one working day.	Media	Annually	**Complete** There were 18 media enquiries.
08	Complete the 'Well Informed' section of the Staff Governance Self-Assessment Monitoring Tool.	Staff Governance Standard	Annually	**Complete** Achieved and evidenced by way of the 'Well Informed' section of the State Hospital's Staff Governance Standard Monitoring Return.
09	To ensure attendance at four of the six State Hospital Board Meetings.	Board	Annually	**Continues to be met**
10	To attend 90% of NHS Scotland Strategic Communications Network Meetings.	NHS Scotland	Annually	**Continues to be met** These meeting were all held via Teams.
11	To ensure representation at the annual NHS Scotland Event.	NHS Scotland	Annually in June	**Continues to be met as appropriate** The event in June 2022 was a two-day in-person event in Aberdeen. Comms did not attend due to the location.

The table below details activity in 2022/23 not covered by KPIs:

No	Workstream	Lead	Outcome	Key Result Area
01	Media Releases	Head of Comms	No Media Releases were issued.	Media Relations
02	Media Features	Head of Comms	No Media Features were produced.	Media Relations
03	Media Leaks	Head of Comms	Nine were reported through Datix.	Media Relations
04	FOI Enquiries	FOI Lead	There was a total of 145 FOI requests (questions) responded to, with 11 questions coming from the media or journalist. Note - Every distinct question is recorded as a request rather than each applicant's request.	Public Relations
05	Academic Published Articles	Research & Development - Manager	The Research Committee Annual Report 2022/23 notes all published journal articles and the delivery of presentations. In 2022/23 there were 14 (11 peer reviewed) published articles and 14 presentations.	Public Relations

6. QUALITY ASSURANCE (QA) OBJECTIVES

The table below details progress against QA objectives set for 2022/23:

No	QA Objective	Source	Lead	Timescale	Status / New Timescale
		Internal Communications			
01	Provide professional advice and direction to the Board, line managers and all teams.	Comms Strategy	Head of Comms	Ongoing	**Continues to be met** This enables the influencing and shaping of communication planning and strategy at all levels, ensuring good communications practice is firmly embedded in everyday service development, delivery, and change.
02	Review Communications Risk Register.	Risk Management	Head of Comms	Every three months	**Continues to be met**
03	Ensure effective communication with relevant stakeholders to share updates relating to strategic priorities including sickness absence and nursing resource utilisation.	Chief Executive / Service Strategy / Directors' Objectives	All Directors	Ongoing	**Continues to be met**
04	Support the Board and Organisational Management Team (OMT) through effective communications for staff.	Board / OMT	Comms	Ongoing	**Continues to be met** A dedicated staff bulletin is produced following each Board and OMT meeting. Additionally staff bulletins in 2022/23 were produced in support of Operational Arrangements, Infection Control, and Leadership.
05	Review the State Hospital's Corporate Document Standards in support of good corporate governance.	Comms Strategy	Head of Comms	-	**New for 2023/24**
06	Review and update of State Hospital publications / information sheets.	Comms Strategy	Comms	-	**New for 2023/24**
07	Review and update of State Hospital Banner Stands following rebrand.	Head of Comms	Comms	-	**New for 2023/24**

No	QA Objective	Source	Lead	Timescale	Status / New Timescale
			Internal Communications (cont'd)		
08	Produce bulletins, newsletters, publications, and other communications to advise staff of what is happening in the Hospital and the wider NHS.	Comms Strategy	Comms	Ongoing	**Continues to be met**
			External Communications		
09	Through effective communications, foster public and political confidence in the care and services provided to protect and enhance understanding of the Hospital.	Comms Strategy	Comms	Ongoing	**Continues to be met**
10	Report Communication incidents / leaks to the Media via Datix.	Comms Strategy	Comms	Ongoing	**Continues to be met**
11	Board meetings, dates, public notices, agendas, minutes, and papers to be advertised / published on the website.	Board	Comms	Ongoing	**Continues to be met**
12	Inform Non-Executives and other identified staff of major events which are likely to attract Media interest.	Board	Head of Comms	Ongoing	**Continues to be met**
13	Keep the Scottish Government up to date on all matters relating to media activity and any correspondence with patients and families and / or carers which may require government officials and / or Ministers to become involved.	Annual Review	Head of Comms	Ongoing	**Continues to be met**
14	Ensure information is provided in an accessible format as required.	Comms Strategy	Comms	Ongoing	**Continues to be met** Redesigned website meets new 2023 accessibility guidelines.
15	Undertake an annual review and update of the content on the Website and produce statistical report via Google Analytics.	Comms Strategy	PR & Digital Comms Officer	January each year	**New for 2023/24** First analytics report following launch of new website in January 2023.

No	QA Objective	Source	Lead	Timescale	Status / New Timescale
			External Communications (cont'd)		
16	Undertake an annual review and update of the content on the ONELAN screens.	Comms Strategy	PR & Digital Comms Officer	By end April annually	**Continues to be met**
17	Undertake annual reviews and updates of the State Hospital's Speakers' Directory and general presentation slides.	Comms Strategy	Head of Comms	By end April annually	**Complete** This update includes feedback from community talks.
18	Review and update the State Hospital Wikipedia page.	Head of Comms	PR & Media Comms Officer	-	**New for 2023/24**
19	Bi-annual review of Media Training requirements for Directors and other identified staff.	Comms Strategy	Chief Executive / Head of Comms	March 2024	**On track** No requirement to date.
20	Familiarisation with 'Dealing with the Media' Guidance for State Hospital Spokespeople.	Comms Strategy	On-Call Directors / CEO	Ongoing	**Continues to be met** Note - This should be read in conjunction with the State Hospital's approved 'Media Lines for On-Call Directors' which have been prepared to assist Directors in responding to media enquiries.
21	Review role of Communications in an Incident.	Head of Comms	Head of Risk & Resilience / Comms	February 2023	**New for 2022/23** **Complete**
22	Maximise key messages about the Hospital's work, role and the services provided thus raising awareness of the Hospital's image, profile, and potential with external audiences locally, nationally, and internationally.	Comms Strategy	Comms	Ongoing	**Continues to be met**
			Strategy / Policy		
23	Conduct an interim review and update (if required) of the Communications Strategy, policies, and procedures.	Comms Strategy	Head of Comms	Annually	**Continues to be met** Media Policy updated February 2023 to reflect Communications staffing appointments in October 2023.

No	QA Objective	Source	Lead	Timescale	Status / New Timescale
			Strategy / Policy (cont'd)		
24	Regular review and update of the Pandemic Influenza Communications Strategy.	Infection Control Committee	Senior Nurse for Infection Control / Head of Comms	Ongoing	**Continues to be met**
25	Undertake Equality Impact Assessments for Communications.	Equality Act	Head of Comms	As required	**Continues to be met** All communication strategies and policies are supported by an Equality Impact Assessment which is reviewed at time of policy review.
26	Following handover of Intranet from eHealth to Comms, review, and update Intranet Maintenance & Development Policy and associated EQIA to reflect changeover.	Comms Strategy / Equality Act	Head of Comms	-	**New for 2023/24**
27	Undertake Data Protection Impact Assessments for Communications.	GDPR	Head of Comms	-	**Continues to be met** Four DPIAs have been developed: Communications Strategy (DPIA approved March 2019), Media Policy (DPIA approved March 2022), the Use of Social Media (DPIA updated November 2021 to reflect designation - Senior Information Risk Owner), and Website Maintenance & Development Policy (DPIA approved March 2022).

7. QUALITY IMPROVEMENT (QI) OBJECTIVES

The following table shows performance against QI objectives set for 2022/23:

No	QI Objective	Source	Lead	Timescale	Status / New Timescale
		Internal Communications			
01	Build capacity for workload via the appointment of two new posts.	Board	Head of Comms	-	**New for 2022/23 Complete** PR & Media Comms Officer appointed October 2022 and PR & Digital Comms Office appointed May 2023.
02	Redevelop the Intranet - current Sharepoint site (now at end of life) will be replaced with the new 'Sharepoint Online' version which is being led nationally for all Boards by National Services Scotland (NSS).	National	Head of eHealth	December 2024	**New for 2023/24** The project is at an early stage pending resources, governance approvals and other necessary requirements to ensure successful implementation across NHS Scotland. Due to this, we cannot provide an exact timescale for implementation for the State Hospital; however, we could be looking at 12-18 months.
03	Redevelop the State Hospital Photo Library.	Head of Comms	PR & Digital Comms Officer	-	**New for 2023/24**
04	Continue to undertake staff engagement exercises to support corporate objectives.	Comms Strategy	Project Lead / Designated Individual	Ongoing	**Continues to be met** Latest engagement exercise – March 2023 – Clinical Model.
05	Develop a Communications and Engagement Plan to support change relating to the clinical care delivery model.	Clinical Model Oversight Board	PCIL and Head of Comms	Ongoing	**Complete** Plan was developed to support implementation of the new Clinical Model (last update February 2023 prior to first moves).
06	Continued support for the new Clinical Model post implementation.	Clinical Model Oversight Board	Project Lead / Comms	-	**New for 2023/24** To ensure staff familiarity.
07	Support the Hospital's implementation of e-Rostering.	Director of Workforce	Head of Comms	-	**New for 2023/24**

No	QI Objective	Source	Lead	Timescale	Status / New Timescale
Internal Communications (cont'd)					
08	Support / promote iMatter.	National	OD Manager / OD & Learning Advisor / Head of Comms	Annually	**Continues to be met**
09	Promote the work of Healthy Working Lives (HWL).	Values & Behaviours Group	OD Manager / PR & Media Comms Officer	Ongoing	**Continues to be met** Achieved through the staff bulletin and the production of resources.
10	Support the 'Excellence Awards' and staff 'Long Service Awards'.	Values & Behaviours Group	OD / Comms	Annually	**Continues to be met**
11	Support the What Matters To You (WMTY) Day.	PCIS	PCIL / Comms	Annually in June	**Continues to be met**
12	Support ad-hoc key events via dedicated staff bulletins / Vision / campaigns as appropriate.	Project Lead	Project Lead / Comms	Ongoing	**Continues to be met** For example, visits and recruitment fayres.
13	Support clinical activities via dedicated staff bulletins.	Project Lead	Project Lead / Comms	Ongoing	**Continues to be met** In 2022/23 activities included: research, and Variance Analysis Tools (VATs).
14	Support non-clinical activities via dedicated staff bulletins.	Project Lead	Project Lead / Comms	Ongoing	**Continues to be met** Activities included: ePayroll, Cyber Security, and Key Vend System.
15	Develop Communications Guides.	Head of Comms	Comms	-	**New for 2022/23** Guides developed for (1) All-User Emails, (2) Staff Bulletins, (3) Social Media Recruitment, (4) SSTS Rostering for Comms, and (5) Wordpress.
16	Develop Standard Operating Procedures (SOPs)	Head of Comms	Comms	-	SOPs developed for (1) CCG Annual Report Redaction, (2) Media Enquiries & Leaks, (3) Patient Voice Recordings, (4) Recruitment, (5) Withholding Patient Mail and (6) Social Media Requests.

No	QI Objective	Source	Lead	Timescale	Status / New Timescale
			Internal Communications (cont'd)		
17	Develop a Departmental Induction Pack for new staff to Communications.	Head of Comms	Head of Comms	-	**New for 2023/24**
18	Annual redesign of the Weekly Staff Bulletin and Special Bulletin.	Board	Comms	Annually	**Continues to be met** New design launch 1 April each year.
19	Explore Microsoft Sway for staff communications.	Head of Comms	PR & Media Comms Officer	-	**New for 2023/24**
20	Develop Asset Registers for Communications.	GDPR	Head of Comms	December 2024	**New for 2023/24** Training took place in July 2022.
			External Communications		
21	Redesign and relaunch of State Hospital Website.	Board	Head of Comms	Ongoing	**New for 2022/23 Complete** New website launched February 2023 with favourable feedback.
22	Ensure research is shared through the Website.	Medical Director	Research & Development Manager / Head of Comms	March 2023	**New for 2022/23 Complete** Research is now a feature of the redesigned website.
23	Explore opportunity for the State Hospital to put a case forward for a State Hospital variant of the NHS Scotland logo that more clearly identifies the State Hospital as an NHS Scotland organisation	Corporate Management Team (CMT)	Head of Comms	-	**New for 2022/23** Business case submitted January 2023. Takes several months for process.
24	Produce suitable content for the Hospital's Social Media channels to maintain an effective presence.	Directors / HODs / Project Leads / Comms	PR & Media Comms Officer	Ongoing	**Continues to be met** Postings increased following appointment of PR & Media Comms Officer in October 2022. Focus (via Twitter, Facebook) was on raising the profile of the State Hospital, recruitment, driving traffic to the new website, and national campaigns.

No	QI Objective	Source	Lead	Timescale	Status / New Timescale
External Communications (cont'd)					
25	Create a State Hospital LinkedIn account.	Head of Comms	PR & Media Comms Officer	End March 2023	**New for 2022/23** Complete March 2023.
26	Ensure recruitment advertising promotes a positive image of the Hospital as a great place to work.	HR Directorate	Comms	Ongoing	**Continues to be met** Social media recruitment posts redesigned November 2022 to include more photos and QR codes.
27	Raising the profile of the Hospital by promoting it as a great place to receive care, and important for all who live in, work in, and visit as well as a major employer for the local community.	Comms Strategy	Comms	Ongoing	**Continues to be met**
28	Explore social media for businesses and ensure two-factor authentication is enabled.	eHealth	PR & Media Comms Officer	-	**New for 2023/24**
29	Explore Twitter Blue Tick / Verified for Businesses.	eHealth	PR & Media Comms Officer	-	**New for 2023/24**
30	Explore Linktree as a means of driving traffic between social media platforms and increasing engagement.	Comms Strategy	PR & Media Comms Officer	-	**New for 2023/24**
31	Review of existing State Hospital videos on the State Hospital YouTube channel with a new to updating or removing.	Comms Strategy	PR & Media Comms Officer / Comms	By July 2023	**New for 2023/24**
32	Produce a series of short educational videos that can be placed on the State Hospital website, YouTube, and other social media channels.	Comms Strategy	PR & Media Comms Officer / Comms	-	**New for 2024/25**
33	Produce key messages / facts including information on items that can be easily misunderstood or can cause concern, e.g., patient outings, patients with autism, misinformation etc.	Comms Strategy	PR & Digital Comms Officer / Comms	-	**New for 2023/24**

No	QI Objective	Source	Lead	Timescale	Status / New Timescale
			External Communications (cont'd)		
34	Provide the Media with background information about the Hospital.	Comms Strategy	PR & Digital Comms Officer / Comms	-	**New for 2023/24**
35	Continue to consider the issuing of Media Releases surrounding good news stories, ensuring the safety and security of patients, staff and visitors is not compromised.	Comms Strategy	PR & Digital Comms Officer / Comms	-	**New for 2023/24**
36	Invite the Media into the Hospital as and when appropriate to help promote positive Media coverage and reduce historic sensationalised, controversial coverage often featured around our patients.	Comms Strategy	PR & Digital Comms Officer / Comms	-	**New from 2023/24**
37	Continue to invite visitors to the Hospital to learn about our work. Visitors include MSPs, Health Board Chairs and senior officials as well as other stakeholders.	Board	CEO / Directors	Ongoing	**Continues to be met** Visits are captured in the Chief Executive's Report to the Board. Of note: Kevin Stewart, Minister for Mental Wellbeing and Social Care (August 2022). Alex McMahon, Chief Nursing Officer visited the State Hospital (September 2022). Wendy Sinclair-Gieben, HM Chief Inspector of Prisons, Scotland, and her team (September 2022). Caroline Lamb, Chief Executive of NHS Scotland and Director-General Health and Social Care (October 2022),
38	Host visit from NHS Lanarkshire Comms staffing as part of their development.	Jackie McColl, Deputy Director of Comms	Head of Comms / Comms	-	**New for 2023/24** Visit by Communications staff from NHS Lanarkshire – May 2023

No	QI Objective	Source	Lead	Timescale	Status / New Timescale
			External Communications (cont'd)		
39	Strengthen relationships with local media.	Comms Strategy	PR & Digital Comms Officer	-	**New for 2023/24**
40	Develop Intellectual Disability Q&A that could be attached to media responses and utilised via Social Media platforms.	Comms Strategy	PR & Digital Comms Officer	-	**New for 2023/24**
41	Produce narrative that covers process from admission to discharge, referring to reason for admission to the State Hospital.	Comms Strategy	PR & Digital Comms Officer	-	**New for 2023/24**
42	Create narrative around detention / restriction orders and review process / rights to appeal.	Comms Strategy	PR & Digital Comms Officer	-	**New for 2023/24**
43	Consider approaching print media and agree a series of features with them – if trust can be established.	Comms Strategy	PR & Digital Comms Officer	-	**New for 2023/24**
44	Actively place features in psychiatric and nursing healthcare journals.	Comms Strategy	PR & Digital Comms Officer	-	**New for 2023/24**
45	Further strengthen relationships with the local media through a series of planned media releases and features. Features could be stand-alone or involve others to enable a 'for / against' approach.	Comms Strategy	PR & Digital Comms Officer	-	**New / from 2023/24**
46	Explore a media monitoring service with an external company.	Chief Executive	PR & Media Comms Officer	-	**New for 2023/24**
47	Redesign of Board Meeting Public Notice so it is more eye-catching / engaging.	Head of Comms	PR & Media Comms Officer	-	**New for 2023/24**

No	QI Objective	Source	Lead	Timescale	Status / New Timescale
			Collaborative Working		
48	Review Memorandum of Understanding (MoU) with another National Board as a means of strengthening resilience during any long-term absence of Head of Comms.	National Boards Collaborative	Head of Comms / Chief Executive	By March 2022	**Complete** MoU with the NHS Golden Jubilee reviewed and updated in December 2022.
49	Review above MoU to establish if this resilience resource is still required.	National Boards Collaborative	Head of Comms / Director of Comms & Stakeholder Engagement and NHS Golden Jubilee	End April 2024	**New for 2024/25**
50	Maintain links with other agencies and forensic services through the Forensic Network.	Comms Strategy	CEO / Medical Director / Other Professions	Ongoing	**Continues to be met**
51	Improve communications with partners about the Hospital's work, aims and successes and look for opportunities to work collaboratively.	Comms Strategy	Head of Comms	Ongoing	**Continues to be met** Good relationships maintained with Scottish Government, Mental Welfare Commission and NHS Boards.
52	Be actively involved in the National Board Review Groups and work supporting the National Collaborative.	National Boards Collaborative	Head of Comms for Comms strand	As required	**Continues to be met** This was paused in 2022/23.
53	Support the NHS Scotland Event.	Scottish Government	Head of Comms	Annually	**Continues to be met** Support is provided via promotion and role of Poster Co-ordinator / management of abstract submissions.
54	Develop the leadership needs of NHS Scotland Communications professionals: Directors of Comms and Comms Heads of Service.	Strategic Comms Group	Strategic Comms Leadership Sub Group	Ongoing	**Paused** This work has been paused since the beginning of the Covid-19 pandemic.

8. EVALUATION OF EFFECTIVENESS

All core Communications objectives, corporate objectives, and legislative requirements were met in 2022/23. The following are examples of positive outcomes evidencing effectiveness achieved during the year.

8.1 Internal Communications

- The appointment of the PR & Media Communications Officer in October 2022 quickly made a valuable contribution to the team.

- The 2022 iMatter Survey saw a response rate of 72% (compared to 69% in 2021) with 65% of teams completing an iMatter Action Plan within the eight-week target timescale. The Board's Employee Engagement Index (EEI) was 75 (74 in 2021).

- The development of Communications Guides and Standard Operating Procedures (SOPs) in year has strengthened governance and effectiveness.

- Workshops / events / training promoted via the Staff Bulletin were well attended evidencing that staff read the bulletin, and the bulletin remains an effective means of promoting these activities.

- Introduction of 'All User Email Request' icon on the Intranet at the beginning of the year, was utilised all year and the process is now well established.

- A review of 'All User' email distribution lists took place which has tightened up governance around who can issue 'All User' emails. The process ensures an identifiable regular need to gain authorisation to issue 'All User' emails.

- The staff bulletin and staff newsletter 'Vision' continue to evolve, keeping staff and volunteers updated on all the latest news internally and externally. Staff requests for dedicated staff bulletins continued to be high throughout this reporting period, as were staff contributions to weekly staff bulletins and Vision.

- A special Wellbeing edition of Vision was introduced / launched in year with a commitment to produce regularly on an ongoing basis.

- Despite the need for redevelopment, the Intranet continued to play a vital role, specifically during the continuation of the Covid-19 pandemic, creating a virtual environment where staff could stay informed, connect, communicate, and share.

- Email system remained effective for issuing urgent communications or those that are not included in the staff bulletin, e.g. weather warnings, grounds access time changes, and items sought or no longer required (with numerous items being exchanged), works on site, programme downtimes, public holiday staffing, lost property etc.

- Feedback arising from the policy consultation process (housed on the Intranet and advertised through the staff bulletin and email system) evidenced that staff took the time to read formal communications, respond and contribute to policy improvement.

- Requests for printed materials continued, evidencing fit for purpose and in demand. A number of new staff information sheets were produced in year including About Us for Restricted Patients Team, Board Biographies, Social Media & Risks, OT for State Hospital patients, Physical Activity Levels are Changing, Acute Care, Smoking & Home Visits, Speak Up Whistleblowing, CCTV, Staff Care & Wellbeing, Guidance on Staff Use of Gym Facilities, and the Patient Welcome Pack.

- Communications support was given to various projects and disciplines throughout the year including the Seminar Series, Staff Wellbeing Centre, Staff Governance Committee ('Well Informed' strand of the Annual Monitoring Return), Corporate Induction materials, Security Refresh project, and the Hospital's Annual Review. Communications staff are key members of the following groups including the Freedom of Information Committee, Climate Change & Sustainability Group, HR & Wellbeing Group, Healthy Working Lives Group, Staff Recognition Steering Group, and Clinical Model Implementation Short-Life Working Group.

8.2 External Communications

- The single biggest achievement of the year was the redesign of the website which is now modern and geared around the needs of our stakeholders.

- Successful local community engagement in relation to CCTV / new cameras as part of the Security Refresh project.

- Engagement in the BBC Documentary on patients with autism in August 2022 to help raise the profile of the State Hospital, to debunk misinformation, and to correct inaccurate reporting where possible.

- Social Media postings have increased following the appointment of the PR & Media Communications Officer. Recruitment and other posts have been redesigned to ensure they are visually appealing and enable maximum engagement. At the end of the year, our range of Social Media channels expanded to include LinkedIn.

- Talks to the local community took place evidencing continued interest in the State Hospital.

- Provision of State Hospital promotional items were sought after during the year as these continue to be popular for recruitment events / fayres and in support of infection control awareness.

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

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

- Through the effective management of media enquiries, we were able to protect the Hospital's reputation by either (1) preventing what could have been a potential news story or (2) by lessening the impact of a negative story through rebutting inaccuracies and providing information to ensure fair and balanced coverage. All media enquiries were shared with the Board and Scottish Government colleagues in support of knowledge exchange, collaborative working, and consistent messaging.

- The distribution list for media enquiries was reviewed and reduced in year to ensure only those that need to receive this information are sent it.

- General enquiries continue to be received through the general State Hospital mailbox (tsh.info@nhs.scot) evidencing that this is not only effective but is a popular resource. Enquiries are daily and can relate to vacancies and placements, requests for psychiatric reports, media enquiries, requests for information, and mental health support.

- During the year, all Communications Strategies and Policies were up to date, and effective, as was all supporting documentation with planned reviews in place for those documents nearing end of life.

9. SUMMARY / CONCLUSION

The challenges of supporting the organisation through another year of Covid-19 restrictions and Communications capacity issues, at the same time as progressing paused tasks and meeting organisational objectives both strategically and operationally, has been significant. Despite this, the Communications Service was integral all year in amplifying and / or localising national messaging, and in respect of resuming State Hospital normal service delivery.

The Communications Service performed to a high standard, delivering a wide ranging and comprehensive communications service to stakeholders. Additionally, others responsible for delivering effective communications continued to achieve agreed objectives.

Overall, core Communications tasks including key performance indicators, quality assurance objectives and quality improvement objectives were delivered. All legislative requirements were met, and all financial targets / savings were achieved.

These achievements were made while adhering to the core values and ways of working that the Board sponsors and are promoted across NHS Scotland.

There is no doubt that the ongoing functioning and future proofing of the Communications Service will benefit from investment in staffing in year to complement the previous single person resource. This will address the growing backlog and enable the Service to explore more modern methods of communication to add variety and ensure existing methods do not become dated. More importantly, the challenges and risks associated with a sole post are now diminished. This much needed investment to sufficiently resource this important Service enables the best and most effective use of resources and will build capacity for the future with an emphasis on appropriate resilience, succession planning and growth.

The Memorandum of Understanding (MoU) with the NHS Golden Jubilee (established 2018) in respect of senior communications cover arrangements in the absence of the Head of Communications will remain in place until the new staff are more developed in their respective roles. The Communications Risk Register (established around a decade ago) continues to outline local cover arrangements in the absence of the Head of Communications.

10. LOOKING FORWARD - Areas of focus in 2023/24 and 2024/25 relate to:

- Producing a Communications Service Induction Handbook for new Communications staff and developing the two new roles within the Communications Service to ensure cohesion and effectiveness.
- Implementing Sharepoint online (new Intranet).
- Establishing an effective media monitoring service.
- Raising the profile of the State Hospital by strengthening and further developing media / social media activity, electronic communications, educational materials, and the production of audio-visual materials.
- Reviewing all Hospital-wide Publications and Banner Stands.
- Redeveloping the Publications Database, Media Database and Photo Library.
- Developing a Communications Information Asset Register.
- Reviewing the State Hospital's Corporate Document Standards.
- Reviewing DPIAs.
- Reviewing the Communications Risk Register every three months.
- Supporting new Hospital priorities such as the implementation of eRostering and Clinical Model pre and post implementation.
- Complete State Hospital Rebranding.

Caroline McCarron Chart.PR MICPR
Head of Communications
4 April 2023

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	26 October 2023
Agenda Reference:	Item No: 23b
Sponsoring Director:	Chief Executive Officer
Author(s):	Head of Communications
Title of Report:	Intranet Upgrade Project
Purpose of Report:	For Noting

1. SITUATION

The Board is seeking an update on the redevelopment of the State Hospital Intranet. This update is provided as at 9 October 2023.

2. BACKGROUND

The current Sharepoint Intranet site (now at end of life) is managed by eHealth. eHealth and Communications are working collaboratively to implement a new Intranet site (Sharepoint Online). When implemented, this will be adopted by Communications with corporate responsibility transferring from eHealth to Communications.

Sharepoint Online is being led nationally for all Boards by National Services Scotland (NSS). The project is still at an early stage nationally pending resources, governance approvals and other necessary requirements to ensure successful implementation across NHS Scotland.

Implementation of SharePoint Online ensures compatibility with all other M365 software, services, and applications. It allows the introduction of various M365 products that we are currently unable to implement without having M365 SharePoint Online, including OneDrive, sensitivity labelling, Business Classification Scheme, Security & Compliance features. It ensures we are utilising the latest software, which is robust, secure, and supported.

A new SharePoint solution would provide staff with a modern interface, with easy navigation, search and collaboration tools, ensure content is accurate, relevant and up-to-date.

SharePoint Online can also be accessed on any device e.g. mobile phones and tablets, without the need to be on site or connected to the Hospital network through remote access, providing greater accessibility for staff.

3. ASSESSMENT

Since the last Board update, good progress has been made to help ensure local readiness for when we get the green light nationally to proceed.

External Engagement

Commissioned Trustmarque to help outline a potential vision for a new Intranet hosted on SharePoint Online. The engagement started with an Art of the Possible session on Day 1 which demonstrated the capabilities provided by SharePoint Online and the wider Microsoft 365 services for an Intranet. On Day 2, a second workshop was held to identify key issues and challenges currently faced by the State Hospital with the current SharePoint 2007 Intranet. Additionally, this provided the opportunity to outline potential requirements for a new SharePoint Online Intranet based on the capabilities demonstrated in the Art of the Possible workshop.

Project Management

- eHealth Project Proposal Form – has been completed and approved.
- Project Plan – this has been developed.
- Project Team – membership has been widened.
- Project Board – this has been set up.

Meeting Legislative Requirements

EQIA (Equality Impact Assessment) – this has been produced and approved.

Sharepoint Familiarisation

Free online Sharepoint training made available via Microsoft has been explored as a first step towards familiarisation. The intention is still to work with someone external to build the new SharePoint site - someone with the experience and knowledge of M365 SharePoint. From there, the State Hospital can create and maintain content. This will involve training for identified staff including Communications, eHealth as appropriate, and Content Contributors.

Next steps

- DPIA (Data Protection Impact Assessment) – initial DPIA developed. Full DPIA to be developed.
- Intranet Upgrade Action Plan – Completion of the Intranet Upgrade Plan (currently under development) to identify content and Content Contributors.
- Content Contributors Engagement - Meet with this group of stakeholders to discuss their requirements in terms of migrating content, whilst also ensuring that the comments from the stakeholder exercise are taken on board. This aspect of the project will take some time.

Timescale

Work continues nationally around governance and support. Until this is complete, the advice nationally is that Sharepoint online is not to be implemented. This means we could still be looking at six months to a year from now. Meantime, the current Intranet site continues to be live and content updated.

4. RECOMMENDATION

The Board is asked to note the update.

MONITORING FORM

How does the proposal support current Policy / Strategy /ADP / Corporate Objectives	This is an upgrade to an existing eHealth system. The Intranet is a key communications tool which supports the Staff Governance Standard in keeping staff Well Informed. It supports the Board's Corporate Objective of 'Better Value' and our Corporate Communications Strategy.
Workforce Implications	Yes, increased work for the Communications Service, the eHealth Department, and Intranet Contributors that help to keep the site updated. It is a lengthy project with many strands.
Financial Implications	These are covered via the eHealth budget as the project is an upgrade to an existing system.
Route to Board Which groups were involved in contributing to the paper and recommendations.	Corporate Management Team.
Risk Assessment (Outline any significant risks and associated mitigation)	The upgrade of the Intranet diminishes the risk associated with the existing version, SharePoint 2007, which is out of support and is no longer fit for purpose. Additionally, the current Intranet also does not integrate with other M365 applications such as Teams and OneDrive, and the security and compliance components of the M365 Programme.
Assessment of Impact on Stakeholder Experience	Positive impact. The new Intranet will be much more modern with more capabilities.
Equality Impact Assessment	Complete.
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	No issues identified.
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One ☐ There are no privacy implications. ☐ There are privacy implications, but full DPIA not needed ☑ There are privacy implications, full DPIA included

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	26 October 2023
Agenda Reference:	Item No: 23c
Sponsoring Director:	Chief Executive Officer
Author(s):	Head of Communications
Title of Report:	State Hospital Branding
Purpose of Report:	For Noting

1. SITUATION

The Board is seeking an update on the position with regards to State Hospital branding. This update is provided as at 9 October 2023.

2. BACKGROUND

The Scottish Government is reviewing the NHS Scotland national branding. This provided an opportunity for the State Hospital to put a case forward for a State Hospital variant of the NHS Scotland logo that more clearly identifies the State Hospital as an NHS Scotland organisation. Branding includes both logo and name. All NHS organisations within the family use NHS in their name and so any change is likely to mean that our name would change to NHS State Hospital and NHS State Hospitals Board for Scotland as appropriate. A business case has been submitted to the Scottish Government. The process will take some time to complete, and we are confident our business case will be successful.

3. ASSESSMENT

The process is taking much longer than anticipated although supported by both the Scottish Government Communications team and our Sponsorship Team. The Sponsorship Team will put this before the Cabinet Secretary shortly. We continue to be patient.

4. RECOMMENDATION

The Board is asked to note the update.

MONITORING FORM

How does the proposal support current Policy / Strategy /ADP / Corporate Objectives	In support of the Board's Communications Strategy and strive to raise the profile of the State Hospital so it can be more clearly identified.
Workforce Implications	Nothing of worthy note. Initial focus will be on implementing the branding on public facing platforms, e.g. website.
Financial Implications	There will be no significant financial implications as there will be no mass update due to materials being updated naturally as per normal review process. This may take up to three years to fully implement as this is the normal review period for publications and policies.
Route to Board Which groups were involved in contributing to the paper and recommendations.	Corporate Management Team.
Risk Assessment (Outline any significant risks and associated mitigation)	No risks identified.
Assessment of Impact on Stakeholder Experience	Positive impact as our identify will be much more visible.
Equality Impact Assessment	N/A.
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	No issues identified.
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One ☑ There are no privacy implications. ☐ There are privacy implications, but full DPIA not needed ☐ There are privacy implications, full DPIA included

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	26 October 2023
Agenda Reference:	Item No: 24
Sponsoring Director:	Director of Security, Resilience and Estates
Author(s):	Programme Director
Title of Report:	Perimeter Security and Enhanced Internal Security Systems Project (Public Session)
Purpose of Report:	For Noting

1. SITUATION

This report to the Board summarises the current status of the Perimeter Security and Enhanced Internal Security Systems project. Board members are asked to note the overall project update, the financial assessment and current issues under consideration by the Project Oversight Board

2. BACKGROUND

The Governance for the project is provided by a Project Oversight Board (POB) co-chaired by the Chief Executive and the Director of Security, Estates and Facilities.

The Project Oversight Board meets monthly. The POB last met on 19th October and is scheduled to meet again on 16th November 2023.

The Programme Director provided an update on the current status on the project, the Project Risk Register and financial details.

3. ASSESSMENT

a) General Project Update:

The project is in the final stages. All quality targets are being met; project timescales have moved(see Project Timescales at 3b below) and costs are projected to overspend (See Finance – Project Cost at point 3c below).

b) Project Timescales

Programme revision 51 has been accepted with Caveats. Revision 52 has been received and is being reviewed. Revision 52 forecast completion is February 2024.

The installation of technology is substantially complete, though some critical areas remain. Full completion of the main technological elements of the project is detailed in programme revision 52.

c) Finance – Project cost

The project is proceeding according to the current projected cost plan, in that the contract with Securitas is due to underspend against budget, including available contingencies. Project management costs and associated contingencies have been affected by the project timescale resulting in a potential overspend (exclusive of VAT) of approximately £594k, 6.3% of the projected final cost.

The key project outline at 15th October is:

Project Start Date:	April 2020
Planned Completion Date:	February 2024
Contract Completion Date:	April 2022
Main Contractor:	Securitas Technology Limited
Lead Advisor:	Thomson Gray
Programme Director:	Doug Irwin
Total Project Cost Projection (Exc. VAT) at 15/10/23:	£9,386,196
Total costs to date (exc. VAT) at 15/10/23:	£8,689,398
Total costs to end of project (Exc. VAT, Inc. Retention)	£ 696,798

The cash flow schedule planned for the months to come is confirmed on a rolling basis in order to ensure that the Hospital's cash flow forecast is aligned and that our SG funding drawdown is scheduled accordingly. All project payments are processed only once certification is received confirming completion of works to date.

While it is not a prerequisite of the project, regular reports to the SG Capital team are also being provided to notify of progress against total budget.

50% of the 5% retention is due to be paid at completion, with the remaining 50% to be paid at the end of the defects and liability period of 2 years.

A Rounded breakdown of actual spend to date (Exc. VAT) at the end of September 2023 is:

Securitas	£ 6.905m (5% retention applied)
Thomson Gray	£ 0.944m
Doig & Smith	£ 0.008m
HVM	£ 0.192m
Staff Costs	£ 0.729m
Income	-£ 0.090m
Total	**£ 8.689m** (Corrected for rounding)

VAT has been excluded from calculations of amounts paid due to the need for the reclaim to be applied for and assessed.

4 RECOMMENDATION

That the Board **note** the current status of the Project

MONITORING FORM

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

THE STATE HOSPITALS BOARD FOR SCOTLAND

AUDIT AND RISK COMMITTEE **A&R(M)23/03**

Minutes of the meeting of the Audit Committee held on Thursday 22 June 2023.

This meeting was conducted virtually by way of MS Teams, and commenced at 09.30am.

Chair:	
Non-Executive Director	David McConnell
Present:	
Non-Executive Director	Stuart Currie
Employee Director	Allan Connor
Non-Executive Director	Pam Radage
In Attendance:	
External Auditor, KPMG	John Blewett
Chief Executive	Gary Jenkins
Internal Auditor, RSMUK	Asam Hussain
Director of Workforce	Linda McGovern (Item 9)
Director of Finance and eHealth	Robin McNaught
Board Chair	Brian Moore
Head of Corporate Governance	Margaret Smith
Director of Security, Estates, and Resilience	David Walker (for items 6, 7 & 22)
External Audit Director, KPMG	Michael Wilkie
Personal Assistant	Julie Warren (Minutes)

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

Mr McConnell welcomed everyone to the meeting, and apologies were noted from Ms Monica Merson, Head of Planning and Performance.

2 CONFLICTS OF INTEREST

There were no conflicts of interest noted in respect of the business on the agenda.

3 MINUTES OF THE PREVIOUS MEETING

The Minutes of the previous meeting held on 6 April 2023 were approved as an accurate record of the meeting.

The Committee:

1. Approved the minutes of the meeting held on 6 April 2023.

4 MATTERS ARISING – ACTION PLAN UPDATE

There were no additional urgent matters which arose for discussion.

5 Action List: Updates

The Committee received the action list and noted progress on the action points from the last meeting.

Members were content to note all actions as complete and closed.

The Committee:

1. Noted the updated action list.

RISK

6 CORPORATE RISK REGISTER

Members received and noted the Corporate Risk Register (CRR) update which Mr Walker gave an overview of.

Mr Walker advised that all risks were in date, and of the proposal to add FD99 Compliance with NIS Audit on the Corporate Risk Register. Mr Walker highlighted that FD96 relating to Cyber Security had been reviewed in detail and that the risk remained at medium. Risk HRD111 continued to be under review, and this would be brought to the next meeting of the Board. In terms of Risk Distribution, currently 13 Corporate Risks had achieved their target grading, with 16 currently not at target level. Two risks had been reduced since the last report, from High to Medium, and one of these was now at target level.

Lastly, in terms of development of the Corporate Risk Register, Mr Walker advised that the Risk and Resilience Team were progressing work to review risk reporting in the context of strategic risk appetite, following the recent development session where this had been discussed. The team were reviewing all areas of high level monitoring and compliance including Corporate Objectives, Critical Success Factors and KPIs. This information would be collated and used to inform the organisation's risk appetite and would be aligned to the four pillars of Better Care, Value, Health and Workforce. A further update in this respect would be provided to the Board.

Ms Radage acknowledged the progress made in terms of ensuring FD99 was on track which gave assurance to the Committee. She referred to risk HRD111, and asked whether further action was required to help mitigate this risk. Lastly, in terms of MD30 - Failure to prevent/mitigate obesity, she asked for further clarification on the Supporting Healthy Choices Project Manager post, and how this work was being supported going forwards. Mr Jenkins advised that an existing secondment had been extended for a one year period because focus on the Supporting Health Choices work stream remained a high priority.

The Committee:

1. Reviewed the current Corporate Risk Register and accepted this as an accurate statement of risk.
2. Agreed that FD99 Compliance with NIS Audit be included on the register.
3. Agreed that no additional information was required to be detailed in future reports.

7 RISK AND RESILIENCE ANNUAL REPORT

The Committee received and noted the Risk and Resilience Annual Report which provided detail of activity undertaken within the Risk and Resilience Department over the period 1 April 2022 until 31 March 2023. Mr Walker provided a detailed summary of areas of good practice within the Risk and Resilience Department, the focused plan and steps which would be taken on the identified issues and potential solutions for these, as well as the future areas of work and potential service developments. He advised he was delighted by the work carried out by a range of staff and teams involved in significant pieces of work within the investigation stages. In terms of the budget, Mr

Walker advised of the hope to bolster the team to ensure a risk and resilience informed approach, and that work was underway to envisage Risk Support Officer Role and Security and Resilience Trainer posts and take recruitment forward.

Mr Walker advised of specific areas of good practice identified which linked to the Clinical Governance Group and Committee. He advised the Local Risk Register was continually under development and assurance was given in terms of active accountability. He advised that the Health and Safety Advisor role had been resourced on a temporary basis through NHS Lanarkshire until substantive recruitment into this post could be progressed.

Mr Connor sought clarity around the planned model for 2023/24, on page four, noting two Resilience and Security Training Officer 0.4 WTE. Mr Walker confirmed this would be one Resilience Training Officer and one Security Training Officer. Mr Connor further made reference to page nine, Training Plan for 2022/23 whereby reference was made to the Risk Management Facilitator post. Mr Walker advised this would be corrected to Risk Manager given the intention to change this post.

Ms Radage acknowledged the extensive level of activity carried out by the Risk and Resilience Department and the very good progress made. She advised it would be helpful to see if the work with Police Scotland could be used as a blueprint and that the 3d model looked interesting. With reference to page 10, Datix Incidents, she questioned the reporting chart style and if this could be revised in future reporting to marry up old ways and new ways of recording incidents on Datix. Mr Walker confirmed this would be the case going forward and that it related to pre Covid-19 ways of working and that a standard template for resources was underway and being reviewed in terms of being mindful of the need to retain the corporate memory. Mr Jenkins further explained the amount of data which was collected at the granular level and how this impacted analysis work. He also made reference to the focused work on eliminating daytime confinement and modified working and the link to how data was collected. Lastly, from a transparency point of view, a review would be conducted to look at how to refine recording within the Datix system.

The Committee:

1. Noted the Risk and Resilience Annual Report for the period 2022/23.

INTERNAL AUDIT

8

Mr McConnell advised of a change to the agenda order and that Item 8 would be taken at the end of this section.

9 INTERNAL AUDIT REPORTS – PAYROLL

Ms McGovern joined the meeting at this time.

Members received and noted the Internal Audit Payroll Report which Mr Hussain gave an overview of the conclusion and key findings on pages two and three, and advised of the internal audit opinion was as follows;

'Taking account of the issues identified, the board can take reasonable assurance that the controls upon which the organisation relies to manage this area are suitably designed, consistently applied and effective. However, we have identified issues that need to be addressed in order to ensure that the control framework is effective in managing the identified area(s).'

He made reference to the checklists in place for the Human Resources Team to ensure leavers and amendments were handled consistently and in a timely manner, however it was identified that a checklist for processing starters was not currently in place, which was rated 'low' risk. Ms McGovern advised that the HR Advisor was currently in the process of developing an additional form to provide additional assurance and that all was now in place from the HR perspective.

Also with a low rating was the point that the Director of Finance and eHealth was currently required to authorise all leaver forms alongside the relevant Director and this indicated over control, as the relevant Director should be sufficient. Mr Jenkins welcomed this comment as he felt it also suggested an element of higher risk to it and approval at a lower level was thought helpful in terms of accountability. Mr McNaught echoed this point and agreed the approval by Director of Finance and eHealth was not required and the process would be reviewed in the near future. Mr Connor commented on the further support that would be available from the new eESS system.

Mr McConnell thanked Mr Hussain for the detailed and helpful report which noted good progress and questioned if he was content with the management responses and timescales noted for progress, to which Mr Hussain agreed.

The Committee:

1. Noted the Internal Audit Payroll Report.

Ms McGovern left the meeting at this time.

10 INTERNAL AUDIT – TRACKING REPORT

The Committee received and noted the Internal Audit Management Actions Tracking Report as at 13 June 2023. Mr Hussain gave an overview of the report and advised that of the 22 actions live on the tracker, 15 were not yet due as they related to actions from recently concluded audits. Of the remaining seven where implementation dates had passed, updates had been provided by management for all seven. Four of the actions relating to the Key Financial Controls (2) and Workforce Planning and Rostering (2) audits have been implemented in full, and three actions relating to the ongoing eHealth project remain ongoing due to the Hospital having to refocus resources and await aspects of national strategy from NSS. Members were also asked to note that some actions had revised dates.

Mr Currie questioned the relevance of target dates being set and thereafter revised notwithstanding acknowledging the work already progressed with and carried out to date. He underlined the need for realistic target setting in this context. He further asked about including a percentage toward completion rate to help demonstrate what work had been carried out to date. This would give the Committee more detail on the background and what was being achieved within each area as well as the direction of travel. Ms Radage queried whether the outstanding actions were a source of concern in terms of available resources to address them. The suggestion in relation to a percentage towards completion rate was welcomed around the table, and the Committee agreed this as the way forward.

Mr McNaught provided further input in relation to impacts at the national level, particularly around Microsoft 365, the programme for which was led by NHS National Services for Scotland (NSS). He explained the aim nonetheless would be to finalise the State Hospital digital strategy subject to this limitation. Mr McNaught highlighted he would discuss this with Head of eHealth to ensure movement was made and reference would be given that internal work was 80% achieved, however 20% of work from NSS still required to be carried out. Mr McConnell however acknowledged that detailed reasons for delays were noted within the report, and noted agreement from the Committee on the proposed way forward in this respect.

Mr Jenkins also commented in relation to the point on resourcing to address the actions, that it would be helpful for the Executive Leadership Team to review the tracker actions cohesively to ensure that these could be progressed effectively.

Action: Mr McNaught / Mr Hussain

The Committee:

1. Noted the Internal Audit Management Actions Tracking Report.
2. Agreed that the report should be developed to demonstrate completion rates for each outstanding action.

3. Work should be progressed on digital strategy locally, noting the impact of delays at a national level.

The committee then returned to Item 8 so that it could be considered in the light of the discussions and decisions taken in Items 9 and 10.

8 INTERNAL AUDIT ANNUAL REPORT 2022/23

Mr Hussain from RSMUK presented the Annual Internal Audit Report for 2022/23 and provided an overall progress update to the Committee. He advised that this report provided an annual internal audit opinion, based upon and limited to the work performed, on the overall adequacy and effectiveness of the organisation's risk management, control and governance processes. Further, that the opinion should contribute to the organisation's annual governance reporting.

Mr Hussain confirmed that the overall opinion for the year was that TSH had an adequate and effective framework for risk management governance and internal control. He led the Committee through the detail of the report, noting the audits conducted within the year and the opinion reached in each. The audit on workforce planning and rostering was highlighted in particular as it had been given a partial assurance opinion. On behalf of the committee Mr McConnell thanked the Internal Audit team for their report and for their work across 2022/23.

The Committee:

1. Noted the Internal Audit Annual Report 2022/23.

ANNUAL REPORTS FROM GOVERNANCE COMMITTIEES

11a. AUDIT AND RISK COMMITTEE

The Committee received its draft Annual Report for consideration and approval. As Chair, Mr McConnell provided an overview of the report, which set out the details of the Committee's programme of meetings, the range of work it had covered and progress made in corporate governance. Members were content to approve the report as giving assurance that the Committee met its remit and was satisfied that internal controls were adequate to ensure that the Board could achieve its policies, aims and objectives. Mr McConnell also thanked members for their work across the year. Mr Currie commented that the extensive report demonstrated the complexity of work carried out throughout the year, which he thought was impressive.

The Committee:

1. Approved the Audit and Risk Committee Annual Report and recommended its submission to the Board later on the same day.

11b. STAFF GOVERNANCE COMMITTEE

The Committee received the annual report from the Staff Governance Committee and agreed that this detailed report provided assurance that the Committee was fulfilling its remit and that adequate and effective staff governance arrangements were in place throughout the year.

The Committee:

1. Approved the Staff Governance Committee Annual Report and recommended its submission to the Board later on the same day.

11c. REMUNERATION COMMITTEE

Members received the annual report from the Remuneration Committee for 2022/23 and agreed that this detailed report demonstrated that the Committee had discharged its responsibilities.

The Committee:

1. Approved the Remuneration Committee Annual Report and recommended its submission to the Board later on the same day.

11d. CLINICAL GOVERNANCE COMMITTEE

Members received the annual report from the Clinical Governance Committee for 2022/23 and agreed that this detailed report provided assurance that the Committee had fulfilled its remit, and that adequate and effective clinical governance arrangements were in place throughout the year.

There was a general discussion on whether work could be progressed on annual reporting for each Committee in the future, to see if these could be aligned to give consistency of reporting. It was agreed that Ms Smith would take this forward during the current year.

Action: Ms Margaret Smith

The Committee:

1. Approved the Clinical Governance Committee Annual Report and recommended its submission to the Board later on the same day.
2. Agreed that presentation of the Committee Annual Reports would be reviewed.

SERVICE AUDITS

12 NATIONAL SINGLE INSTANCE (NSI) AND NSS AUDITS

The Committee received a report to provide an update on the service audits carried out on the NSS National IT Services Contract and National Single Instance (NSI) finance system. Both reports returned an unqualified opinion from the Service Auditors and there were no critical or significant findings.

Both NSS and NHS Ayrshire & Arran provided Boards with copies of their Service Audits so that the TSH Board could gain assurance of the operation of systems on their behalf. Mr McNaught advised the Committee that there were no significant control issues and no high risk recommendations had been identified. It was acknowledged that full reports were available on request.

The Committee:

1. Noted the opinions on both NSS and NSI Audits.

EXTERNAL AUDIT

13 EXTERNAL AUDIT ANNUAL REPORT TO THE BOARD AND THE AUDITOR GENERAL FOR SCOTLAND

Members received the draft External Audit Annual Report for the year end 31 March 2023 which was presented by Mr Wilkie and Mr Blewett from KPMG. Mr Wilkie presented a summary of the report to the Committee, noting that it should be taken in conjunction with the audit plan and strategy presented to the Committee on 6 April 2023.

The report highlighted the key risk areas relevant to the Board and detailed the evidence received to mitigate these. Mr Wilkie advised the audit was substantially complete and there were no significant changes to the audit plan and strategy. Subject to the Committee's approval of the financial statements, KPMG expected to be in a position to offer an unqualified audit opinion , provided that the outstanding matters noted on page four of the report were satisfactorily resolved.

This related to two key areas, firstly re the carrying amount of revalued Land & Buildings. Mr Wilkie confirmed that there had been a review of this, and identified a potential issue in relation to the

Valuation exercise. However, this was consistent with other NHS Boards and was therefore accepted.

Secondly, in relation to liabilities and related expenses for purchases of goods or services, it was found that there was risk of some not being fully identified and recorded. Mr Wilkie confirmed, however, that no such instances where further accruals should have been recorded were found and it was confirmed that accruals had not been understated.

Mr Wilkie highlighted three areas in which recommendations were made for follow up, relating to assets under construction, and the need for full review of risk recognition following completion of any project. He also noted the recommendation that management follow the annual accounts guidance and inform Scottish Government in all cases where they are providing or NHS debt and that the provision was consistently applied. Finally that there should be further review and co-ordination in relation to the input of NSS in relation to the preparation of the annual accounts.

Mr McNaught welcomed the positive report and noted the benefit of having a new perspective from external auditors and the input and focus on areas required to be progressed. He gave a detailed account of planned intention to progress with recommendations and reiterated the preparedness to address any over accrual, oversight of NSS input and assets under construction as noted above. Further recruitment was underway within the Finance Team which would support this.

Mr Currie echoed the point regarding having a fresh review from new Auditors in place, with the importance to understand the re focus. He further acknowledged the disadvantage the loss of one member of staff could be destabilising and impactful within a small organisation. At the same time, it was essential to demonstrate value for money with public funds. He added that all of the components of the security re-fresh project would have different lives so it would be helpful to have detailed mapping of the risk overall. Mr McNaught agreed noting that the many individual costs within the project would be collated into asset groupings with appropriate useful lives.

Mr McConnell provided a summary on behalf of the Committee, including the unadjusted items within reporting. Mr McConnell also noted the areas in which work was continuing to be completed, noting nothing material was attached to this. KPMG gave confirmation that nothing material expected from areas requiring further adjustment, therefore members could approve on that basis. Mr Wilkie confirmed that in these circumstances the Committee could recommend submission to the Board, and that it would only be the case of material change in the final version that this would need to return to the Committee and Board. Mr McConnell also thanked the External Auditors for their work in this, the first year of their appointment.

The Committee:

1. Noted the External Audit Annual Report to the Board and the Auditor General for Scotland and its submission to the Board later on the same day.

STATUTORY ANNUAL ACCOUNTS

14 STATUTORY ANNUAL ACCOUNTS

Members received the Annual Report and Accounts for the year ending 31 March 2023 which was presented by Mr McNaught. Mr McNaught provided the Committee with a detailed overview of the accounts, emphasising the main points and noting the range of statutory disclosures. He noted that the main format of the Annual Report and Accounts had only minor changes from the prior year, and had been reviewed by KPMG in their first year as external auditors, and from whom a draft unqualified audit opinion had been given. Mr McNaught also thanked the TSH Finance Team plus the NSS staff for all their diligent work done on the year-end process.

Mr McConnell made reference to page four of the report ‘Memorandum For In Year Outturn’ and questioned if the context was of a three year rolling outturn funds from Scottish Government that were referred to, or captured elsewhere. Mr McNaught advised there was no explicit disclosure required within the accounts and that the information would continue to be reported on throughout the time period.

Mr McConnell sought specific assurance from the Committee in relation to the governance statement that they were content for this to be submitted later today to the Board. The Committee approved the Governance Statement as was presented on page 15 in the report and agreed its submission to the Board meeting. Mr McConnell noted that the final version of the accounts would be prepared, but did not require to return to the Committee as there were no expected material changes.

The Committee:

1. Acknowledged that the above changes would be reflected in the accounts for electronic signing and noted their thanks to Robin McNaught and the Finance Team and both the internal and external auditors and agreed to recommend the statutory annual accounts for 2022/23 to the Board for final approval.

ANNUAL AUDIT AND RISK COMMITTEE ASSURANCE STATEMENT TO THE BOARD

15 ANNUAL AUDIT COMMITTEE ASSURANCE STATEMENT TO THE BOARD

Members received a report from the Director of Finance and eHealth in respect of the Annual Audit Committee Assurance Statement to the Board for 2022/23.

Mr McNaught advised that this paper was for the Audit Committee to present to the Board, at its meeting today, to give specific assurance that the Performance Report, Accountability Report and the accounts themselves could to be signed with the Audit Committee's and external auditors' approval, within their remit, and on the basis of assurance from the annual reports received from the governance committees.

Mr McConnell noted that this paper brought together all of the assurance documents presented at this meeting of the Committee, including the annual reports of each of the governance committees. He noted that the Committee had received confirmation that the external auditor expected to complete their audit and issue an unqualified opinion on the annual accounts, and this was currently subject to small adjustments which were not issues of materiality to this opinion.

Members noted that the assurance statement would inform the Board in its collective decision for:

- Approval and signing of the performance report
- Approval and signing of the accountability report
- The approval and the adoption of the Annual Accounts which have been separately presented to this Committee and the Board for consideration.

Members approved the annual Audit Assurance Statement for 2022/23 for submission to the Board.

The Committee:

1. Approved the annual Audit and Risk Committee Assurance Statement for 2022/23 for submission to the Board.

PATIENTS FUNDS ACCOUNTS

16 PATIENTS FUNDS ACCOUNTS

The Committee received a paper relating to the Patients' Funds Accounts and Mr McNaught provided a summary of the report. He confirmed that reporting represented a summary of patient income and expenditure, and that there had been a net outflow throughout the year. The Committee agreed the report would be passed to the Board on 22 June 2023 for approval and signature by the Chief Executive and Director of Finance & eHealth.

The Committee:

1. Approved the abstract of receipts and payments of patients' private funds for the year ended 31 March 2023 to be presented to the Board for its approval.

NATIONAL AUDITS

17 AUDIT SCOTLAND REPORTING

It was confirmed in reporting that there have been no Audit Scotland Reports issued relevant to The State Hospital since the last update, as circulated and discussed at the Audit Committee of April 2023. Mr McNaught highlighted the recent publication in relation to climate change.

The Committee:

1. Noted the update.

FOR INFORMATION

18 REPORT ON WAIVERS OF SFI TENDERING REQUIREMENTS

Members received and noted the Waiver of Standing Financial Instructions (SFI) tendering requirements report during 2022/23, whereby the Board's SFI permit the Chief Executive and eHealth and Finance Director to waive the requirement for competitive tendering or quotations if they jointly agreed that it would not be possible or desirable to undertake or obtain same having regard for all the circumstances. Members were content to note the paper received.

Mr McNaught emphasized that within the State Hospital, waivers were applied at a more stringent level compared to most other NHS Boards, with a limit at £50k commonly applied. Mr McConnell also noted the usefulness of detailed reporting, demonstrating the reasons for applying waivers as these were presented in the report.

The Committee:

1. Noted the Report on Waivers of Standing Financial Instructions Tendering Requirements.

19 SUMMARY OF LOSSES AND SPECIAL PAYMENTS

The Committee received and noted the Summary of Losses and Special Payments register update. Mr McNaught provided a summary of the report and advised there were no significant matters to raise to members.

The Committee:

1. Noted the Summary of Losses and Special Payments update report.

20 FRAUD UPDATE / ACTION PLAN

Members received and noted the Fraud update which provided the Committee with an update on fraud allegations and notifications received from Counter Fraud Services. Mr McNaught advised there had been two alerts this quarter received which were circulated site wide via a Staff Bulletin and uploaded to the Counter Fraud section in the home page of the intranet. Lastly, he advised that no issues of concern had been been raised in the last quarter.

The Committee also received the Fraud Action Plan which listed the activities gauged by Counter Fraud Services (CFS) level of engagement with each Board and these activities were the basis of discussion during their annual engagement visit.

The Committee:

1. Noted the Fraud update report and Fraud Action Plan.

21 CYBER CRIME REPORT

The Committee received and noted the report on Cyber Crime which was presented by Mr McNaught who advised that the organisation continued to maintain active cyber security monitoring and alerting locally and nationally. He advised that we were also notified by NHS Scotland National Cyber Security Operations Centre (NHSS NCSOC) and the National Cyber Security Centre (NCSC) of any active alerts or concerns. The alert status for a cyber-attack in the UK continues to be high. Members noted the content of the report.

The Committee:

1. Noted the Cyber Crime Report.

22 SECURITY, RESILIENCE, HEALTH AND SAFETY OVERSIGHT GROUP UPDATE

Members received and noted the report summarising the work of the Security, Resilience, Health and Safety Oversight group and to provide assurance to the Committee that robust arrangements were in place for monitoring and reviewing the effectiveness of management arrangements within the Board.

The Committee:

1. Noted the Security, Resilience, Health and Safety Oversight group update.

23 FINANCE, EHEALTH AND AUDIT GROUP UPDATE

Members noted the update from Finance, eHealth and Audit Group. Mr McNaught advised there were no matters highlighted which were deemed to require escalation to the Committee for consideration.

The Committee:

1. Noted the Finance, eHealth and Audit Group update.

24 ANY RELEVANT ISSUES ARISING TO BE SHARED WITH GOVERNANCE COMMITTIEES

Members acknowledged that the Internal Audit Payroll Report would be shared with Staff Governance Committee as routine practice in line with their Workplan.

Action: Secretariat

25 ANY OTHER BUSINESS

There was no further competent business raised for discussion at this meeting.

26 DATE OF NEXT MEETING

The next meeting will take place on Thursday 28 September 2023 at 9.45am via MS Teams.

End of meeting 1130 hours.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	26 October 2023
Agenda Reference:	Item No: 25b
Title of Report:	Audit and Risk Committee – Highlight Report
Purpose of Report:	For Noting

This report provides the Board with an update on the key points arising from the Audit and Risk Committee meeting that took place on 28 September 2023.

1	Internal Audit	The Committee received the Internal Audit Progress Report setting out the audit activities for the year to date against the Audit Plan, and agreed planned updates to timings. Also, the Internal Auditors presented their Management Actions Tracking Report, showing steady progress on Audit Actions. The Committee also received and noted a report on Internal Audit's Environmental, Social and Governance Review which recorded reasonable assurance on the areas examined.
2	Corporate Risk Register	The Committee received and noted a report on the position on the Corporate Risk Register setting out the risk status and highlighting recent updates.
3	Counter Fraud	The committee noted progress on engagement activities within this workstream; and noted an update on Communication. There was review of the Fraud Action Plan statement from Counter Fraud Services; and also noted that no further revision had been made to the Top Risks identified from the FRAM (Appendix).
4	Cyber Crime Report	The Committee received and noted a report on the broader Cybercrime position. There have been no alerts to report from our antivirus system.
5	Policy Update	The Committee received and noted the six-monthly report on TSH Policy Updates. Of 116 local policies, 5 were past their review date.
6	External Audit	The External Auditors provided a verbal update on their 2023/24 audit work, which is an early, preparatory stage and will lead to the submission of a formal Audit Plan to a subsequent meeting.
7	Reports from	The Committee received and noted update reports on their recent

	Governance Groups	work from the Security, Resilience and Health and Safety Group, and from the Finance, eHealth and Audit Group.
8	Workplan	The committee reviewed its workplan for 2024.
9	Committee Effectiveness	The committee members had completed a self-effectiveness checklist in accordance with the audit Handbook. The overall conclusion was positive as to the Committee's view of its effectiveness, with a small number matters to consider going forward.
10	Issues to be shared with others	The Committee flagged that the findings of the Internal Audit review of Environmental, Social and Governance could be usefully shared with Board members more widely.

RECOMMENDATION

The Board is asked to note this update, and that the full meeting minute will be presented, once approved by the Committee

MONITORING FORM

How does the proposal support current Policy / Strategy / ADP / Corporate Objectives	As part of corporate governance arrangements, to ensure committee business is reported timeously to the Board.
Workforce Implications	None through reporting – information update
Financial Implications	None through reporting – information update
Route to Board Which groups were involved in contributing to the paper and recommendations.	Board requested, pending approval of formal minutes
Risk Assessment (Outline any significant risks and associated mitigation)	Committee update only as part of governance process – no specific risks to be considered unless raised by committee chair/members for Board attention.
Assessment of Impact on Stakeholder Experience	No assessment required as part of reporting
Equality Impact Assessment	Not required
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	N/A
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One X There are no privacy implications. ☐ There are privacy implications, but full DPIA not needed ☐ There are privacy implications, full DPIA included